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DEPARTMENT OF MEDICAID SERVICES
BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

Capitol Annex
702 Capital Avenue, Room 125
Frankfort, Kentucky

September 3, 2019
commencing at 1:00 p.m.

Jolinda S. Todd, RPR, CCR(KY)
Registered Professional Reporter

A T T E N D A N C E

TAC Committee Members:

Sheila A. Schuster, PhD, Chair

Valerie Mudd

Mike Barry

Steve Shannon

MS. SCHUSTER: All right. Good afternoon. If you are here for the Behavioral Health TAC meeting, you are in the right place at the right time so welcome. And let's go around and do introductions as we usually do. And we'll start in the far corner over there with Dr. --

MS. McKUNE: Hi, I'm Liz McKune with Passport Health Plan.

MR. HANNAH: Dave Hannah with Passport.

MR. CAIN: Micah Cain with Passport.

MS. WHITE: I'm Shannon White with Centerstone Kentucky. I'm hiding in the corner back here.

MS. SCHUSTER: Shannon doesn't want anybody to ask her anything about Supreme Court rulings.

How about up here in the front?

PARTICIPANT: Thanks for bringing it up.

MR. BLACKBURN: Shan Blackburn from the Pathways.

MR. KELLY: Marc Kelly, Pathways.

MS. LAKES: Anita Lakes, New Beginnings.

MR. BARRY: Mike Barry, PAR, People Advocating Recovery.

MR. SHANNON: Steve Shannon, KARP, member of the TAC.
MR. JOHNSON: Dustin Johnson with Aetna.
MS. BOWLING: Sarah Bowling with Aetna.
MS. STEARMAN: Liz Stearman with Anthem.
MR. RUDD: Andrew Rudd, Anthem.
MS. SCHUSTER: Okay.
MR. WICKEY: Bert Wickey, Johnson & Johnson.
MS. JESSEE: Rebecca Jessee, Janssen.
MR. BALDWIN: Bart Baldwin, Kentucky Health Resource Alliance, United Kentucky.
MS. SCHUSTER: You're sitting in for --
MR. BALDWIN: -- and the other behavioral health stuff.
MS. SCHUSTER: -- for Sarah --
MR. BALDWIN: Yeah.
MS. SCHUSTER: -- who is still out on maternity leave; right?
MR. BALDWIN: Yes.
MS. SCHUSTER: Okay.
MR. CALLEBS: Johnny Callebs, The Columbus Organization.
MS. HASS: Mary Hass. I'm with the Brain Injury Association, Kentucky Chapter

Legislative Advocate.
MS. ABBOTT: Susan Abbott, P&A.
MS. SHUFFETT: Christy Shuffett, New Beginnings.
MS. LOY: Beverly Loy, Adanta.
MS. SAVAGE: Meg Savage, Kentucky Coalition Against Domestic Violence.
MS. SCHUSTER: Yeah, we got them over there.
PARTICIPANT: Oh, you do?
MS. SCHUSTER: Yeah.
PARTICIPANT: I'm sorry.
MS. PAXTON: Julie Paxton, Mountain Comprehensive Care Center.
MS. ADAMS: Kathy Adams, Children's Alliance.
MS. SANDWOOD: Michelle Sanborn, Children's Alliance.
MS. GUNNING: Kelly Gunning, NAMI Lex.
MS. MUDD: Valerie Mudd, NAMI Lexington, Participation Station and member of the TAC.
MS. JOHNSON: Ramona Johnson, Bridgehaven in Louisville, Kentucky.
MR. BALDWIN: Brad Leedy with Bridgehaven.

MS. SCHUSTER: Great.
PARTICIPANT: We've got some people --
MS. SCHUSTER: Oh, I'm sorry.
MR. VENNARI: Joe Vennari, Humana CareSource.
MS. MOWDER: Kristan Mowder, Humana CareSource.
MS. SCHUSTER: Okay, great. So we have a quorum. We have Valerie Mudd, Steve Shannon, Mike Barry and myself as members of the TAC. Gayle DiCesare had e-mailed me and said she had to go out of town. And Sarah is still on maternity leave.

So I sent out to you-all -- and you also have it in your packet, the minutes from the July 9th Behavioral Health TAC meeting, which we adopt from the report that was given by Steve Shannon at the July 25th MAC meeting. So I would entertain a motion from one of the TAC members to approve the minutes.
MS. MUDD: So moved.
MS. SCHUSTER: Valerie.
MR. SHANNON: Second.
MS. SCHUSTER: And Steve second. All in

favor signify by saying aye.
PARTICIPANTS: Aye.
MS. SCHUSTER: And opposed, like sign.
(No response.)
MS. SCHUSTER: All right. Thank you very much.
Steve, was there any report you wanted to make from the July 27th, MAC meeting?
MR. SHANNON: No.
MS. SCHUSTER: There was no report?
MR. SHANNON: The report was given. It was a wonderful experience for KARP.
MS. SCHUSTER: Let the record show that Steve really enjoyed the experience. We might let him do it again since he enjoyed it so much.
Welcome, we've got sign-in sheets. Hi, Abner. And handouts here.
(Dr. Rayapati enters the meeting.)
MS. SCHUSTER: And I sent you-all -- I believe I sent those out, the responses from DMS to our July recommendations. They were received with great acclaim. Not.
So the Commissioner was very clear in telling us that we are not advisory to

Medicaid. We are advisory only to the Medicaid Advisory Council, which is advisory to Medicaid. Now, I see that as at least being advisory once removed, but apparently that is not.

MS. MUDD: We have to take an extra step up, I think.

MS. SCHUSTER: Yeah, that's not what the Commissioner wanted to share with us. This was in -- you know, we've made this recommendation before, that it would be super helpful if the Medicaid Department would discuss with us, since we have some expertise in this area, some of the changes that they are proposing, either in regulations or in rates or any number of things, change in policy, and let us respond to it beforehand, as opposed to after it's in place and then everybody is upset and coming back and responding to it then. But it doesn't look like that's going to happen.

MS. SANBORN: Can they respond to the MAC?

MS. SCHUSTER: I'm sorry?

MS. SANBORN: Why would they respond to the

MAC if they don't want to respond to the TAC? If they respond to the MAC, would -- isn't that the purpose of that group?

MS. SCHUSTER: You know, the MAC has raised that issue, Michelle, a number of times. And, in fact, if you go back to the Medicaid waiver, the creation of Kentucky Health, the MAC was very upset about the fact that they are advisory and been in statute for years and years and years and had not been notified by DMS that there was any work going on to develop a waiver that was going to significantly change Medicaid. And there's not been any response from Medicaid to that, nor has there been since then. So I think we can continue to raise the issue of the -- you know, if you go to those MAC meetings -- and I missed the one in July. But, generally speaking, the Commissioner comes up and responds to things that are on the agenda without a whole lot of give and take with the rest of the MAC, and almost no give and take -- or actually none, with what the TACs are recommending or saying.

MR. SHANNON: There's no discussion.
MS. SCHUSTER: I mean, there really is no discussion.
MR. SHANNON: MAC members may ask a question, but Medicaid never answers.
MS. SCHUSTER: Never answers. Yeah. And we -- you know, if you've been to those meetings, when you come up to give your report, you're really giving your report to the MAC. You're not giving your report to the -- to the Medicaid staff. Although, I've been known to turn and look at them and say things to them while I'm giving them my report, because there are things that we're saying that have to do with them. But there really is no format for any real give and take.

Now, you remember at the MAC meeting, maybe back in March, that the MAC did point out to DMS that they were not responding very positively to any of the recommendations from any of the TACs and they gave some examples. I think several of ours were on there, as well as some to the consumer TAC, which they have routinely kind

of dissed. And, actually, I don't think anything really came of that, you know, they kind of heard it and then went on.

I don't know if there's a recommendation that we can make.

MS. MUDD: Listen to us.

MS. SCHUSTER: (Laughs). A plea from the people. You know, to make them more responsive or -- or interactive.

You know, this Commissioner, for whatever reason, has kind of taken it on as a personal mission to I think interact very negatively with the TACs. I didn't print out for you-all, but they sent a response. The MAC asked the Attorney General for an opinion about teleconferencing. And the Attorney General essentially said, yes, you can still have an open meeting and meet open meeting requirements and have teleconferencing. And when they sent that out, there was a memo from the Commissioner that essentially said, yeah, you can do it, but we're not going to help at all. We're not going to help you set it up. We're not going to maintain it or make sure that it

meets the requirements. And then it was followed up with a e-mail from Charlie Hughes, who is kind of the liaison with the TACs, saying if you really want to do it, you would have to work with the IT people over at the Cabinet and it's $75.00 an hour to get their consultation and --

MS. MUDD: Ridiculous.

MS. SCHUSTER: -- you know, this, that and the other thing.

MR. SHANNON: And I think some TACs will pay it or they will do it themselves and have the technology. I think the ones that don't, it -- it creates an unlevel playing field.

MS. SCHUSTER: Yeah. So we've never pushed it.

MR. SHANNON: Helps the physicians, as opposed to driving to a meeting.

MS. SCHUSTER: Yeah, I think the physician would do it. The Consumer TAC is looking at it very strongly, because they have a consumer member who needs attendant care and the Cabinet has refused to make any arrangements to pay for that attendant

care, and so it's very difficult for that individual to participate. And usually P&A has some staff there to help. And the last time they had attendant care there and I don't know who paid for it. I'm sure the consumer does not have the funds to do that. And so they're looking, I think, very strongly at perhaps doing teleconferencing for the Consumer TAC to make it easier for people with disabilities to participate.

We've never done it in part, because we've always gathered a fairly large group and we've not had trouble getting a quorum. Most of our TAC members are in the golden triangle and so forth. Gayle is the furthest one now, from Owensboro, but -- suffice it to say that there's not a very positive working relationship, from my perspective any way, between DMS and the -- and the TACs in terms of how we do our -- our business.

MS. HASS: Well, Sheila, don't take it personally if she doesn't have a -- you know, I used to have a monthly meeting.

And all those have been cancelled, so you know --

MS. SCHUSTER: With -- with the Medicaid Commissioner?

MS. HASS: Basically since Carol came on.

MS. SCHUSTER: Well, it's unfortunate, because like in this next one we're talking about regulations, like these BHSO Regs that we've talked about now in two different meetings. We're going to talk about it again today. And it caused such a stir both the mental health BHSOs and the substance abuse disorder BHSOs, and really threatened the livelihood of peer support folks and their ability to maintain full-time employment while they're in recovery and working as a --

MS. GUNNING: Well, I mean, they provided the services.

MS. SCHUSTER: Yeah, yeah. So she went through, you know, all the -- all the steps that they had gone through and so forth. I was underwhelmed.

PARTICIPANT: That wasn't even accurate --

MS. SCHUSTER: We recommended --

PARTICIPANT: -- that's true.
MS. SCHUSTER: We recommended something on KI-HIPP, and they did get a frequently asked questions document. There still are lots of questions being raised by some outside groups, like Kentucky Voices for Health, about whether KI-HIPP is really a program that we want to encourage people to participate in or not. And we raised, again, some concerns about the copays, particularly those below 100 percent of the federal poverty level.
MR. SHANNON: In her comment was the first time I heard it articulated that way.
MS. SCHUSTER: Which was?
MR. SHANNON: That they have a copay, but it can believe waived. They can't be denied services.
MS. SCHUSTER: They cannot be denied services.
MR. SHANNON: So they still -- so they can accumulate copay debt, essentially.
MS. SCHUSTER: Well, and there's been some --
MR. SHANNON: Which is meaningless.

MS. SCHUSTER: -- some question raised by some attorneys about whether providers would be in a position to go after people if they have continuous lack of copay payments and they've accumulated a good bit of debt and whether that would affect somebody's credit rating, if they have a credit rating, and some of those kinds of things that could really put people in jeopardy. So, yeah, I thought, Steve, that they didn't have a copay and could not be denied services.

MR. SHANNON: They have -- they have a copay.

MS. SCHUSTER: They have a copay.

MR. SHANNON: They must get services.

MS. SCHUSTER: Yeah.

MR. SHANNON: And they're going to owe someone $3.00.

MS. SCHUSTER: Yeah. And then we, again, tried to ask about the 1915(c) waiver design panels and having access to those people. And I think they want us to still -- I'm assuming, Mary, this response essentially says continue to e-mail.

MS. HASS: Yes.
MR. SHANNON: Mystery box.
MS. SCHUSTER: Mystery box, yeah.
MS. HASS: Yeah, state your complaint, then you can -- they would open up the complaint -- not the -- not the complaint, excuse me, the comment line. And that it was still open and I could voice my concerns there.
MS. SCHUSTER: This last one, Marc, is that issues that you brought up at the TAC probably four months ago --
MR. KELLY: Uh-huh (affirmative).
MS. SCHUSTER: -- two meetings ago or so. Do you have any information about anybody? I mean, do you have -- what they're saying is they can't do anything about it until they have a name and a date and, you know, a person who was denied transportation.
MR. KELLY: I can come up with that.
MS. SCHUSTER: Well, I think that's the only way that we're going to push the envelope on this.
Julie, I think when we talked about this four months ago, you said that that

happened sometimes in your region, too, in Mountain, where you have somebody at a -- say a hospital that doesn't have a psych unit and needs to get transported, a mental health patient.

MS. PAXTON: -- transportation issue.

MS. SCHUSTER: And the transportation issues. I think the only way that we're going to get on that is to literally get the Medicaid member's name, serial number, all that kind of stuff, and a date when they were denied service. And I think it's an issue well worth pushing.

MR. KELLY: Yeah, I agree.

MS. SCHUSTER: Now, DMS says that they will do something about it if we get them that information. So we might reach out, Steve, also, and, Bart, to some other comp care centers, because I think -- particularly the ones out in rural areas are definitely experiencing this.

We also heard from Beth Partin, who is the chair of the MAC and has her own rural health clinic out in Adair County, that it's happening at primary care settings. So they

have people that are there, have a mental health crisis, they can't get anybody to come and pick them up. So I think we're going to have to do some reaching out and get people -- it would be very helpful if you report something directly to Medicaid, if you would let me know. I don't need to know the person's name, but I'd like to be able to document that Pathways had two or three people and Mountain had, you know, three or four people and on these dates you-all sent that information in. Because otherwise, there's no way to hold them accountable to do anything.

MR. KELLY: Yeah, I thought they would want something specific, case specific, so...

MS. SCHUSTER: Yeah, yeah. So you're going to have to have at least a name and a Medicaid number and a date when they were denied and maybe the location. Is that doable, Julie, you think?

MS. PAXTON: I think so.

MS. SCHUSTER: Okay. Bart, I'll do up an e-mail or something. We'll send it out. You can send it to your folks and Steve

will send it out as well, because I think we ought to stay on this because this -- to me it's a really important issue for us to pursue.

MS. GUNNING: Sheila, is the only -- the only issue with the private ambulance company, is that they don't have a payer source? Because I was -- that was not my understanding. These are private businesses, right, that are refusing to transport people? And is their only reason for refusing the transport is that there's no payer source?

MR. KELLY: What they say is if they're ambulatory, that they can't transport.

MS. GUNNING: That's what the problem is. And these are private businesses. I mean, I don't really know what dog DMS has in that fight. It's really policy that's the problem.

MR. KELLY: Well, the client's a Medicaid recipient.

MS. GUNNING: Yeah.

MR. KELLY: Medicaid would be the payer.

MS. SCHUSTER: Yeah.

MS. GUNNING: But that's not why they're refusing to transport them.
MS. SCHUSTER: Well, no, but when you first brought it up you were being told, oh, no we don't have to take mental health patients.
MR. KELLY: That's -- that's --
MS. GUNNING: That's what I mean. Is that the problem or is it --
MR. KELLY: That's exactly what they were saying.
MS. GUNNING: -- or is it the payer source?
MR. KELLY: That's what I was told first. They don't transport any mental health patients.
MS. GUNNING: Well, that's a discrimination.
MR. KELLY: And I said, well --
MS. SCHUSTER: Exactly. That's why we brought it up so strongly.
MS. GUNNING: I mean, it's more of a discriminatory thing than it is a DMS issue.
MR. KELLY: Yeah. And I said, well, why? And they said, well, if they're ambulatory,

we don't have to transport. That was all --

MS. GUNNING: I'm wondering if that.

MR. KELLY: -- based on --

PARTICIPANT: They transport lots of people who are ambulatory but have medical issues.

MS. GUNNING: That's right.

MR. KELLY: Sure.

MS. GUNNING: It's a parity issue and a discrimination issue.

MS. SCHUSTER: Yeah, so we're going to need to know what that reason for denial was, because we were first told that, oh, no, I don't have to transport them if they're mental health. But I think we're -- we're only talking about the Medicaid folks. I mean, we can't --

MR. KELLY: Right.

MS. SCHUSTER: -- deal with people that have private insurance who are not Medicaid.

MS. GUNNING: Right.

MS. SCHUSTER: But the only way we can get Medicaid to look at it is --

MS. GUNNING: But I think the -- that they

don't want to deal with a group of people that can be problematic.

MR. KELLY: Well, they said regulation. They said it's the regulation.

MS. GUNNING: What regulation?

MR. KELLY: Well, that's -- yeah, that's what I was getting ready to ask. Is it a Medicaid regulation? Is it a --

MS. GUNNING: I think it's their own private policy.

MR. KELLY: Is it a licensure regulation? I guess that would be a -- I don't know.

PARTICIPANT: Unless -- well, there could be regulations for emergency medical services providers.

MS. GUNNING: But I don't think they can do that.

MR. SHANNON: You take Medicaid, you take Medicaid.

MS. SCHUSTER: Yeah, I was going to say, if you take Medicaid, you take Medicaid. I think that's right.

MR. SHANNON: They said they would --

PARTICIPANT: Right. If the client doesn't meet medical necessity because

they're ambu- -- that word.
MR. KELLY: Ambulatory.
PARTICIPANT: There we go. Then that's why they're using that as the reason that we don't have to transport them. Medicare is not going to cover it. It comes back to your point, there's no payer source.
MR. KELLY: I got different answers from different --
MS. GUNNING: Of course, you will. They're --
MR. KELLY: -- because it was a safety issue, was one. And then we never transport mental health patients because that's a 202A. I said, no, this is involuntary admission.
MS. GUNNING: Right.
MR. KELLY: And they said, well, we've never transported mental health patients before. I'm like...
MS. SCHUSTER: That's what I'd like to nail them on, is that one.
MR. KELLY: Yeah.
MS. GUNNING: That's the key.
MS. SCHUSTER: Because that's -- that's

really discriminatory.
MS. GUNNING: Yes.
MS. SCHUSTER: Okay. Well, let's -- if you-all would go back and see what you can document, I think would be the case and let me know.
MR. KELLY: Be easy to find out
MS. SCHUSTER: Okay. Thank you.
MS. GUNNING: Because their license might be, you know, suspended if they're practicing discriminatory things against certain classes of patients.
MS. SCHUSTER: Well, and I think when we talked before -- because I think Sarah was here and said, let's find out what the reg is. If the problem is in the reg, then let's push for some change in the wording to make sure that it encompasses people with mental health issues.
MS. MUDD: And it should be just like any other ambulatory service, I would think, that if a patient is -- is admitted then that is covered; right?
MS. SCHUSTER: Right. Yeah, should be.
PARTICIPANT: Well, I guess that falls

under whether it's an emergency or not. Because I can see where they're saying it's not medical -- medical necessary for the emergency transport, but they need a transport for a voluntary. So it's kind of splitting hairs.

MR. KELLY: It's a brain emergency.

PARTICIPANT: Huh?

MR. KELLY: It's a brain emergency.

PARTICIPANT: Well, I know. I'm being --

MR. KELLY: Oh, yeah, I know

MS. GUNNING: It's interesting how it's different from county to county.

PARTICIPANT: If you don't understand what you're dealing with, why -- why you would think that.

MS. SCHUSTER: Right.

PARTICIPANT: Not that it's allowable. I'm just trying to think how -- it's part of the problem. You know, it may not even be a Medicare reg. But that's okay. We can work on that one, too.

MS. GUNNING: I think it's a company issue.

MS. SCHUSTER: Well, I think it may very well. And it may have a historic --

they've never done it, so they're not going to start now kind of thing, or somebody said, oh, you don't have to do that, so -- well, it was --

MR. KELLY: You know, it was a forceful response, like they had said that several times, you know. That was the stock response, you know, right away.

MS. SCHUSTER: All right. Well, let's -- let's pursue that.

Speaking of regs, we have some concerns about the BHSO regs. We talked about them at some length last meeting and the meeting before. I asked Ramona and Brad to come, because probably Bridgehaven as a mental health BHSO is just affected as anybody. You want to talk about what your -- what you submitted in terms of your response or what the situation is for you-all, Ramona?

MS. JOHNSON: Yeah, there are -- there are a number of issues with the regulations, but the two primary issues that are the most concerning is that when they started writing the regs for the substance use

providers, BHSO 2 and 3, the original BHSO regs had language in it that treated people with severe mental illness and co-occurring, secondary substance use disorders. So every -- every reference to treating a co-occurring disorder, somebody with a primary severe mental illness has been stricken from those regulations. So that puts a BHSO 1, who is treating people with severe mental illness, who over 50 percent report initially that they have some form of substance use problem; more than that after we get them into treatment, we find out. And we address that through -- simultaneously in the program, in our program with dual diagnosis groups, et cetera. They remove CADC counselors as billable providers from the BHSO 1 regs. That's an issue for the substance use people, too, I believe.

MS. GUNNING: Especially for co-occurring --

MS. JOHNSON: Yeah.

MS. GUNNING: -- integrated treatment.

MS. JOHNSON: And putting -- putting a

group of people who have severe mental illness as their primary diagnosis into the substance use disorder treatment center makes no sense at all, because they're not prepared to deal with the severe mental illness.

MS. GUNNING: They won't.

MS. JOHNSON: And won't, right. Can't and won't. I mean, so it kind of -- it leaves over 50 percent of people with an SMI unable to access treatment for the co-occurring substance use in the same setting, which is the evidence-based practice that they treat them together.

And I pointed out in both the written comments that I submitted and then the comments -- we went to the hearing and made comments that for people with severe mental illness, usually their substance of choice, if you will, is alcohol, maybe cannabis. You know, they are not the narcotic, they're not the opioid addicts. They're not the people who are abusing, you know, Oxycodone and heroin. They're usually not addicted to those substances. They have self-medicated

with alcohol or cannabis to reduce the anxiety, to dull the voices. And once they get into treatment to treat those symptoms, they very often don't feel the need to use the substance. Many of them quit using on their own. And the others, we work with to help them -- in a harm reduction model to help them deal with that. So I pointed out that, you know, I know we're addressing -- we have a serious opioid crisis in the state. And we are fully supportive of servicing to treat people with that severe addiction. I mean, it needs to be addressed, but not at the expense of people with --

MS. GUNNING: Amen.

MS. JOHNSON: -- a severe mental illness, who need help with alcohol and marijuana, makes -- just doesn't make any sense. That was -- and it's been removed everywhere in the reg. So with every single service, it's listed, you know, co-occurring.

MS. SCHUSTER: Co-occurring --

PARTICIPANT: So it's totally out?

MS. JOHNSON: Oh, yeah.

PARTICIPANT: On one, two and three, or just the Section 1.

MS. GUNNING: Section 1.

PARTICIPANT: Everywhere.

MR. KELLY: Co-occurring language removed --

MS. GUNNING: It's removed from two and three, too.

MR. SHANNON: Yeah, BHSO 1 --

MS. JOHNSON: It's removed from the BHSO 1 regs. Co-occurring disorders are referenced in the 2 and 3 regs, but not the SMI part. Just as a co-occurring disorder. It doesn't say what the rest of it is. And so my point that I made in writing at the hearing was that, you know, a simple language change would -- would fix this. If you put into the BHSO 1 regs that the services are provided for people with a severe mental illness and co-occurring substance use disorder when severe mental illness is the primary diagnosis. That's really all they need to do to allow BHSO 1 to continue treat the population that we've -- that we're already treating and

not have those people, really have nowhere to go.

MS. GUNNING: They have nowhere to go, right.

MS. JOHNSON: And it's just -- just a language issue.

MR. BALDWIN: Well, and the other thing we ran into and made comments on was, you got somebody that you're treating for mental illness. And, of course, with the treatment you find out they have a substance abuse --

MS. JOHNSON: Right.

MR. BALDWIN: -- issue. It's very common.

MS. JOHNSON: Yeah.

MR. BALDWIN: And at that point, you're a BHSO 1 --

MS. JOHNSON: Uh-huh (affirmative).

MR. BALDWIN: -- you don't -- you're not able to --

MS. JOHNSON: Right.

MR. BALDWIN: And so -- but you want to -- like I say, you want to integrate the service --

MS. JOHNSON: You can't.

MR. BALDWIN: And it's not like you can't -- then what do you -- what do you do? You're instantly out of clients --

MS. JOHNSON: Right.

MR. BALDWIN: -- as soon as you find that out. So how do you...

MS. GUNNING: And you really can't refer somebody to a substance use disorder treatment center when their primary diagnosis is mental illness.

MS. JOHNSON: No. And if we -- and we do. I mean, when we encounter somebody when they've been in treatment for a while with us and been in recovery program and -- and occasionally there's somebody we find out later that they are using heroin. They are, you know, abusing narcotics. We don't keep them at Bridgehaven. We refer them on to a substance use provider and say this addiction has to be treated before we can do anything. I mean, because it's -- that's a -- that becomes the primary at that point.

MR. BALDWIN: Takes away your flexibility and your ability to integrate care.

MS. SCHUSTER: Kelly?

MS. GUNNING: What we're seeing in the mental health court -- and it is a court where the primary diagnosis is a serious mental illness to get into the court. What we're seeing is 80 percent of our people right now in the court program -- and it's been as high as 85 percent -- also have a co-occurring disorder. And many of the times, unlike what Ramona has seen, we are seeing -- we're seeing poly substance use disorder. So we're seeing heroin, we're seeing methamphetamine, we're seeing alcohol, we're seeing marijuana, we're seeing benzos. We're seeing anything basically the people can get on the street and get their hands on. And the problem is when we try to refer them out, because we can't get them in a BHSO or whatever, they're not allowed to take their psychotropic medications and be in many of those straight-line AODE programs. That's a violation of the program.

MS. JOHNSON: Right.

MR. CALLEBS: Psychotropics are?

MS. GUNNING: Yeah.
MR. SHANNON: Medication.
PARTICIPANT: Medications, period.
MS. GUNNING: But the psychotropics for sure.
MR. SHANNON: Yeah.
MS. GUNNING: We have people actually honestly hang up on us when they hear their list of medications. They don't talk to us. And that's to treat their primary serious mental illness.
MS. SCHUSTER: Kathy?
MS. ADAMS: One of the issues that has troubled us and we sent our little question to the, you know, DMS issues and got a response back, but we're still not clear. But it appears that you can only be a BHSO 1 or a 2 or a 3. It's not as if you're a 3, that then you're able to do Tier 1 and 2 services.
MR. BALDWIN: That's right.
MS. ADAMS: So we're trying to get clarification on that, which would kind of address Bart's issue. But when they responded back initially, they use the --

the word primary. When SUD is primary, then you have to go to a Tier 2 or a Tier 3. So we've gone back and asked, well, what if mental health, they're being treated in a BHSO 1 for mental health and an SUD comes up, but it's not necessarily primary, would then they -- could they still be seen by a 1? So we're trying to get some clarification. But, again, they're --

MR. BALDWIN: Right.

MS. GUNNING: The best practice is integrated treatment and it shouldn't matter what tier you are.

MS. JOHNSON: Totally agree to that.

MS. SCHUSTER: What it reminds me of is all the years when Medicaid didn't recognize SUD.

MS. JOHNSON: Right.

MR. BALDWIN: Right.

MS. GUNNING: Right.

MR. BALDWIN: Yeah.

MS. SCHUSTER: And the CMHCs were seeing the Medicaid people and they knew that they had co-occurring and they couldn't speak --

they could speak to the mental illness, the depression, but they couldn't speak to the person self-medicating with alcohol or other -- other drugs --

MS. GUNNING: It needs to be integrated.

MS. SCHUSTER: -- or they did and they didn't record it and they couldn't diagnose it.

MR. SHANNON: Or they did and had a threat of recoupment.

MS. SCHUSTER: And they had the threat of recoupment.

MR. SHANNON: Under the Fletcher administration.

MS. SCHUSTER: We're back in those -- those days --

MR. SHANNON: Right.

MS. SCHUSTER: -- and the 2s and 3s don't have the personnel to treat the primary --

MS. GUNNING: No.

MS. SCHUSTER: -- mental illness.

MS. GUNNING: And you can't -- they don't meet the criteria because of their meds. So you can't get them in anyway.

MS. SCHUSTER: So what happened at the --

at the public hearing, Ramona? You had --
MS. JOHNSON: Well, at the public hearing there may have been other mental health providers there. The only people I heard testify were substance use providers besides Bridgehaven.
MS. GUNNING: When was it?
MS. SCHUSTER: A week ago Monday.
MS. GUNNING: A week ago?
MS. JOHNSON: Last Monday. Well, we barely found out about it.
MS. GUNNING: I didn't even know about it or we would have been there.
MS. SCHUSTER: Yeah, I think Ramona found out about it over the weekend and it was 9:00 on that Monday morning.
MS. GUNNING: Well, that's how they send out the notices on all these changes.
MS. SCHUSTER: Yeah.
MS. JOHNSON: Yeah, we found out about it on -- I think it was Friday morning and put our team together Friday afternoon, got our talking points together Friday afternoon and over the weekend, and we were there on Monday.

MS. GUNNING: Where was it, Ramona?
MS. SCHUSTER: Over at the Cabinet.
MS. JOHNSON: Over at the CFHF. We took a team with us. We had our board chair. I was there. Our chief operating officer and three peer support specialists. One peer support specialist who was our team leader. So he supervises the peers who work on our program. And our two peers who are -- run the center for -- where they do all the peer support training, where they do RAP training up around the state for peers. They maintain the central database of peer support specialists and their contact information. Technical assistance to organizations in terms of, you know, how to, you know, best integrate peer support services into their programs. All that -- and that part is funded by the Department of Behavioral Health. So here's the department wanting peer support services, evidence-based services and -- and really, in some cases, pushing the CMHCs to increase that service and we're -- we're trying to help do that. We definitely

integrated them into our services.

And then they write regs that limit the peer support specialists to 120 units of service a week. Now, if the peer does only individual work, then that's probably a 30-hour week and they have a day that they have, you know, notes and other stuff. So you got -- that's a full-time position. But if a peer does groups -- and most of our peers do a lot of groups, and I would think that substance use peers would also be working on -- in a group -- a group format for the most part. They're going to use up those 120 units in a day and a half.

MS. GUNNING: Yeah.

MR. SHANNON: Now, we were told the units for group, you count individuals, but you really count the time, is what we were told.

MS. JOHNSON: The what?

MR. SHANNON: Well, if a person has a group for half an hour, that's two 15-minute units. You don't count the heads. That's what Medicaid told us to do. So you don't go through -- you don't burn through the

units that way. Even though you bill group based on the individuals participating, you count --

MS. JOHNSON: The units --

MR. SHANNON: -- the time -- but you count the time that they are doing the service.

MS. JOHNSON: Well, that's not clear at all --

MS. GUNNING: No.

MS. JOHNSON: -- in the regulation.

MR. SHANNON: Well, no. That's why we asked them the question. That was their response to us. So we thought the 30 hours was more than enough, because you're not going to spend much more than that doing group or individual anyway. It's not prudent. So that was what we were told. But I'll find that e-mail and send it to you.

MS. JOHNSON: Okay. That's --

MR. SHANNON: But it's clear -- I agree with you, it wasn't clear --

MS. GUNNING: Could you send it to us, too, Steve --

MR. SHANNON: Yeah.

MS. GUNNING: -- because we were told you do count the heads.

MS. JOHNSON: Yeah. And --

MS. GUNNING: And it's per person.

MS. JOHNSON: -- if you count the heads, then you --

MR. SHANNON: Yeah.

MS. JOHNSON: -- you're done by a day and a half --

MR. SHANNON: Yeah, you're done by noon Tuesday.

MS. JOHNSON: And then peers can't work full time. Then why are we going out and training peers to be peer specialists and then saying, oh, well, but you can't work full time; you can't make a living at this. And our point in the hearing and on paper was that, you know, we're talking about people who have lived experience, who have fought their way into recovery from their mental health -- from their mental illness. They have maybe started working part time, maintain their disability and their benefits, and then decided to go full time with an organization, go off of disability,

go with the company's commercial insurance claim, which isn't that what the administration wants anyway? They're working full-time. They're on our insurance plan. They have a 401(k). They have other benefits. They -- they've gone beyond that. They don't want to go back on disability again. And then they're saying -- and we haven't -- I mean, we haven't broadcast this to our peers because we don't want everybody panicking --

MS. GUNNING: Panicking.

MS. JOHNSON: -- before possibly this can be worked out. But we did pull in these three peers because we knew that -- we felt like they could handle it and, you know, not spread panic among the peers, but...

MS. GUNNING: What about the rate changes, too?

MS. JOHNSON: The rate change is a disaster.

MS. GUNNING: It's a horrible thing.

MS. JOHNSON: Total disaster. Of course, the group limitation from 12 to eight decreases your capacity to provide services

and peers -- serving peer people, so that means you have to do more groups with people who can't work full time unless Steve's interpretation is correct.

MR. SHANNON: Not my interpretation.

MS. JOHNSON: Well, their interpretation --

MR. SHANNON: Medicaid's interpretation --

MS. JOHNSON: Yeah.

MR. SHANNON: -- to me.

MS. JOHNSON: Yeah.

MR. SHANNON: It's not mine.

MS. GUNNING: But it doesn't make sense with the way they've set up billing for peers --

MR. SHANNON: I understand.

MS. JOHNSON: We've seen two different rates. The published rate that's the Medicaid non-facility or, you know, rates is a -- is a service rate of like $6.25.

MS. GUNNING: 6.25.

MS. JOHNSON: So if you do a group of eight people, you earn $50. Well, that's -- nobody can -- nobody can operate like that.

MS. SCHUSTER: Right, right.

MS. JOHNSON: There also was discussion of

a 15-minute rate of $3.40 something cents, which was -- by the time you look at that reduction and you look at the reduction of the number of people in group, and if the 120 unit limitation worked the way we thought it did, that was like a 90 percent reduction in revenue from peer support services. So once again how can --

MS. GUNNING: Billable peer support.

MS. JOHNSON: Yeah, billable peer support, so like an agency before to have peer support specialists on staff. And we know and we have seen that that's one of the most effective interventions we have in our toolkit, is our peer specialists.

MS. GUNNING: Especially in dual diagnosis.

MS. JOHNSON: Well, they are the ones that make the best connection with the consumers.

MS. SCHUSTER: Right.

MS. JOHNSON: And so they gave very strong testimony, I think, in the hearing. One of them talked about the power of the group and why it was so important for consumers to hear another person with lived

experience say, well, yes, you can live on your own and you can work even if you hear voices because I do.

MS. SCHUSTER: Right, which you can't get anyplace else.

MS. JOHNSON: So those -- there were other -- there were other issues with the regs. There were issues with screening and assessment with BHSO 1, again, taking out all reference to co-occurring disorders, so we can only discuss the mental health disorders. Well, I'm sorry, but we can't do that.

MS. GUNNING: Which goes totally against the changes they made three or four years ago wanting everybody to be dual, SUD and SMI --

MS. JOHNSON: Well, and that, everybody's required to be accredited. We're accredited by KARP. If we did all -- only for mental health issues, we would not be meeting the KARP standards, which requires to do a thorough --

MS. GUNNING: Integrated.

MS. JOHNSON: -- psycho-social assessment,

look at substance use, look at physical health issues. I mean, it has to be a complete and thorough assessment. We can't just address those issues. Those questions have to be asked. So I pointed out that the regulations -- if we comply with that regulation, which we can't, it will put us in noncompliance --

MS. GUNNING: In noncompliance.

MS. JOHNSON: -- with the KARP standards. And, of course, regulations require accreditation. And then there were some -- there was a set of OIG regs at the same time that mentioned the BHSO 1s, and they -- they were different than the regs, the BHSO regs -- ACT teams, services and composition of ACT teams.

And then targeted case management was not included in the BHSO 1 regs. They told us it wasn't because case management had their own regulation, so they didn't need to be in the BHSO regs. But in the OIG reg, targeted case management was listed. And the OIG reg is about Behavioral Health Service Organizations. In that reg they

removed the targeted case management for people with SMI, co-occurring disorders and chronic and complex physical health issues. And those are -- those are the people that we need to do case management for.

MS. GUNNING: Those are the most important people.

MS. JOHNSON: So they just screwed it up all the way around.

MS. GUNNING: They just decimated it, actually.

PARTICIPANT: Did you point that out to them?

MS. JOHNSON: Yes, politely.

MS. SCHUSTER: Well, it sounds like a lot of people sent in -- you sent in comments, Bart.

MR. BALDWIN: We sent in comments.

MS. GUNNING: I would have if I had known.

MS. JOHNSON: And there were a number of substance use providers at the hearing, who talked -- of course, their biggest issue was requirement for the physician to be an addictionologist.

MS. GUNNING: Yes. Psychiatrist.

MS. JOHNSON: But they can't make that happen immediately.
MR. SHANNON: Can't find them.
MS. JOHNSON: They're not there. They --
MR. SHANNON: They're -- they're hiding.
MS. JOHNSON: -- a certain number of months or years, or whatever the requirement is, to even take the test. So they can't meet that. And the other -- and their other issue was the peer -- the peer support restrictions, so...
MS. SCHUSTER: And, Kathy, some of you're groups sent in comments as well?
MS. ADAMS: We sent in pages of comments.
MS. GUNNING: I can't even believe we didn't.
MS. ADAMS: I had a whole -- I had a whole grid for -- of --
MS. GUNNING: Ramona and Bart and you-all, when you-all stuff like that, will you please see that Sheila gets that information, so that we can get it out to everybody? Because I hate to say it, but it almost seems purposeful that they don't get this stuff out.

MR. SHANNON: Well --
MS. GUNNING: I mean, it's not --
MR. SHANNON: -- talked about it the last time --
MS. JOHNSON: We're not --
MR. SHANNON: -- we were here.
MS. GUNNING: I don't guess I was here.
MR. SHANNON: The BHSO regs were. And the last section of those regs list the time. Now, I pointed out that the hearing was going to be whenever it was and submit your request by August 31st. Well, the hearing was on August 26th. I said, that ain't right, so -- but -- so it was posted then. We talked about it at the meeting that it was available and they were going to send them out. And they did a conference call --
MS. JOHNSON: They really didn't send them out, though. They -- in their responses to the TAC --
MR. SHANNON: Right.
MS. JOHNSON: -- they said that they sent the regs by e-mail to providers. They never did.

MR. SHANNON: You know, I never saw them. I went to the website. But it was clearly posted --

MS. JOHNSON: We never got them and we got them -- you were kind enough to send them to us or we would have had to have done the same thing.

MS. GUNNING: That would have been nice, send them out.

MR. SHANNON: Yeah, it was discussed here. They were on the website then.

MS. GUNNING: -- brought it up, so I guess I didn't hear that part.

MR. BALDWIN: Any time there's a reg buried all the way at the very bottom --

MS. JOHNSON: They're in.

MR. SHANNON: Above the rules.

MR. BALDWIN: Yeah. There's a due -- comments are due --

MS. JOHNSON: Yeah.

MR. BALDWIN: -- date and then a hearing.

MS. JOHNSON: Yeah.

MR. BALDWIN: A question on the hearing. Did they -- did they respond to anything or did they just --

MS. JOHNSON: No, no. They had the recorder there, the person who records, and the person who was listening. And she wasn't from Medicaid. She was from --

MR. SHANNON: Legal services.

MR. BALDWIN: I think the whole term hearing is a little --

MR. SHANNON: Yeah, it's not.

MS. JOHNSON: And she said --

MR. SHANNON: Oral argument.

MS. JOHNSON: -- I am here to hear your comments. I will not answer questions. There will -- this is not a discussion.

MS. MUDD: What's the point?

MS. JOHNSON: Yeah.

MS. GUNNING: Well, to be heard.

MS. SCHUSTER: Well, all you're doing is talking to a court reporter, so it gets into the system, you know. And occasionally -- and it's been a long time, we used to get media over there sometimes if we were going to get a big turnout of people with the --

MR. SHANNON: The SEL --

MS. SCHUSTER: -- the SEL once upon a time,

you know.

It's a good reminder to me, Kelly, that when we talk about these regs in here, that I need to send out just that piece about what the timeline is and how you submit those comments.

MS. GUNNING: Yeah, because I know DeBars (phonetic) and I brought it up about the psychiatrist.

MS. SCHUSTER: Yeah, but we talked about it. I guess because we assumed that people know that when there's a reg, there's always --

MR. SHANNON: -- say the regs were at?

MS. SCHUSTER: -- there's always a written comment period.

MS. GUNNING: Yeah.

MS. SCHUSTER: Sometimes a public hearing and sometimes not.

MS. GUNNING: Somehow we just missed this one.

MS. SCHUSTER: So --

PARTICIPANT: But that's even difficult to find on their website --

MS. GUNNING: I'm just saying they don't

make it easy --
MS. SCHUSTER: No, they don't make it easy.
MS. GUNNING: And so if we can help each other in any way, that would be great.
MS. JOHNSON: They don't make it easy to find.
MR. BALDWIN: Well, and the other piece is, given our discussion earlier, you can't assume anything unless you brought up --
MS. JOHNSON: No.
MR. BALDWIN: -- necessarily, so --
MR. SHANNON: No. I got -- I got a comment --
MR. BALDWIN: Be more diligent about the regs.
MR. SHANNON: It was not appropriate at this time. What's does that mean?
MR. BALDWIN: Well, that just means through the TAC or whatever --
MR. SHANNON: Yeah. But even the reg comment, that's -- that's the response you get back, right?
MR. BALDWIN: Yeah.
MS. GUNNING: I just -- it's hard to comb through every single thing when you got 20

programs going on.

MR. BALDWIN: Yeah.

MS. GUNNING: And so if we had a way to find the needle in the haystack, just a heads up would be nice, but...

MR. BALDWIN: Absolutely.

MS. GUNNING: I mean, we miss them sometimes.

MS. JOHNSON: Excuse me. I don't want you to miss them because we need your voices.

Somebody over on the other side of the little wall there said something about not being able to be a one and a two at the same time or whatever.

MS. SCHUSTER: Yeah.

MS. JOHNSON: I actually got a response from Ann -- what's Ann's last name?

MS. SCHUSTER: Holland?

MS. JOHNSON: Yes, from Ann Holland. She responded when I first submitted my comments that I copied them to her. And she said that if we wanted to continue providing services to people with co-occurring substance use, that we could get an AODE and we could be licensed as a

BHSO 2 and a 1. So we could be licensed as a one and a two. And with the AODE license could provide -- continue to provide co-occurring services. So she did say you could be licensed in two different levels. And, now, add did to that streamline government and cut red tape and reduce administrative burden.

MS. GUNNING: Does it change the --

MS. JOHNSON: No. It increases all of that.

MS. GUNNING: -- reimbursement rate?

MS. JOHNSON: That was part of the issues that I thought of when doing all of this, is because a BHSO had to have an AODE, two licenses to provide substance abuse services and we thought this was streamlining it. But I thought initially, especially from the webinar, that when they had providers, you had to go in and select which kind of a BHSO you are, if you are already a BHSO.

PARTICIPANT: Yeah.

MS. SCHUSTER: Right.

MS. JOHNSON: It wasn't multiple choice,

was it? I mean, you couldn't pick a Tier 1 and a Tier 2 and Tier 3, could you? You could only pick one. And so that's where I think a lot of the confusion has come in. So now they're saying you can have --

MS. GUNNING: -- you can have multiple licenses.

MS. SCHUSTER: Well, one person at DMS said that.

MS. JOHNSON: That does nothing to streamline what we thought they were working to fix to begin with.

PARTICIPANT: No. It just makes it more complicated.

MR. SHANNON: CMHCs had to have the CMHC and AODE license. Then about four years ago they said you don't need the AODE license.

MS. SCHUSTER: Yeah.

MR. SHANNON: Then about two years ago they said you need the AODE license.

MS. SCHUSTER: Yeah.

MR. SHANNON: And most of the centers kept their AODE license just because, you know, they had it. But, yeah, it was the same

question, why do you have to do that?

PARTICIPANT: And then all the AODE regs change.

MS. GUNNING: Yeah, they changed them and didn't tell anyone.

MS. SCHUSTER: I did send comments from the Mental Health Coalition at literally at 10:00 p.m. on the last day that they were due, just simply saying, you know, you're really hurting people with severe mental illness. You're not allowing them to continue to be treated with the BHSO where they have been treated; 50 percent of the people are going to have co-occurring. And then talked about the irony of this administration that's been pushing so hard for people to get to work, to make it impossible for people who are peer support specialists to actually earn a livelihood. So I'll send that out. I meant to make a copy of that. It was last minute, but I'll send that out.

I wonder if there's any kind of recommendation that the BH TAC should make about this issue. I mean, it's almost the

only other thing that we've got available to us. And I guess I'm wondering about a recommendation that says, this is such an important issue because of the potential loss of services to people with severe mental illness, 50 percent or more of whom are going to have a co-occurring disorder to get treatment from knowledgeable providers.

MS. GUNNING: Integrated treatment.

MS. SCHUSTER: Integrated treatment.

MS. GUNNING: Integrated is base treatment, because --

MS. SCHUSTER: Evidence based.

MS. GUNNING: -- integrated is evidence based.

MS. SCHUSTER: Yeah, evidence based.

PARTICIPANT: Well, and here's -- is there an option of the Behavioral Health TAC requesting that this be put on the next MAC agenda and it be an agenda item where folks could go to the table and --

PARTICIPANT: There you go.

PARTICIPANT: -- voice the concern since the Commissioner would be in the room?

MR. SHANNON: Yeah. I also think, why

don't we instead of recommend to DMS, we recommend to the MAC that they request of DMS. Because they say the MAC is -- they answer to the MAC. So I think the same strategy is run everything through the MAC and let the chair of the MAC know that's what we're doing. Because the MAC I think will say it's a MAC issue. But if the MAC goes back to DMS saying we need to have this conversation, right?

PARTICIPANT: I think the implementation date for the regs needs to be postponed.

MS. GUNNING: It was crazy.

PARTICIPANT: It needs to be suspended because --

PARTICIPANT: It was July 1, wasn't it?

PARTICIPANT: It was July 1 --

MS. GUNNING: Yeah.

PARTICIPANT: -- got them.

MR. KELLY: And we got them on the 27th.

MS. SCHUSTER: Yeah, because these are E-regs.

PARTICIPANT: The E-regs.

MS. SCHUSTER: They're in -- they're in effect.

PARTICIPANT: And so technically they're in effect.
MR. SHANNON: They're in effect right now.
PARTICIPANT: And we've already gotten notification from one MCO that they're going to pay the posted peer group rate of 6.25.
MS. GUNNING: Yeah, we have -- we've heard it.
PARTICIPANT: Yeah.
MS. GUNNING: You know, remember, we're not a BHSO, but our people have to rely on those services.
MS. SCHUSTER: Right.
MS. GUNNING: We have never become a BHSO, but I'm very concerned about what's happening in this realm because all of our individuals are impacted by it.
MS. SCHUSTER: So what's our recommendation? I'm a little bit confused about what you want to do? Steve, when you're saying recommend to the --
MR. SHANNON: Well, I think we need that recommendation. But going forward, based on the Commissioner's response, we report

to the MAC. So do we make a recommendation to the MAC that they make a request to DMS. So on all our recommendations, right, every recommendation that we make, we recommend that DMS communicate to the relevant TAC or MAC, right? And we recommend that the MAC request of DMS to communicate the relevant. Because our relationship is with the MAC. So can we get the MAC to make those requests? I think the next meeting the requests to the MAC is the BHSO changes are on the agenda.

MS. MUDD: So the MAC will request the response from CMS?

MR. SHANNON: Do we get a different response. Because the Commissioner said we report to the TAC, right?

PARTICIPANT: Correct.

PARTICIPANT: You'll have to clarify --

MR. SHANNON: Advisory capacity to the council.

MS. SCHUSTER: Right.

MR. SHANNON: So we're advising the council to make a request of DMS. Because as it stands now, they just say the MAC is who

your relationship is with; we want to have the relationship -- we want to get answers.

MS. SCHUSTER: Yeah, but the problem is we're two more months down the road.

MR. SHANNON: I know. But next month we request BHSO be on the agenda.

MS. GUNNING: And, you know, to clarify what Steve heard about the units and is it per unit or per head? That's a very confusing thing.

PARTICIPANT: That's CMS issues --

MS. GUNNING: It's very important that we know.

MR. SHANNON: One recommendation is -- I would make, is at the next MAC meeting at the end of September that the BHSO regs are on the agenda and public comments are accepted on those BHSO regs.

MR. BALDWIN: But what you're thinking, Sheila, is the MAC --

MS. SCHUSTER: There's no way to make that to the MAC --

MR. BALDWIN: The MAC wouldn't do anything --

MS. SCHUSTER: -- in time for their -- for

their -- for us to get on the agenda for September. That's my --

MR. BALDWIN: They wouldn't --

MS. SCHUSTER: -- that's my concern.

MR. BALDWIN: They wouldn't act on it until they met again and then you're two months --

MS. SCHUSTER: And then you're two months down.

MR. SHANNON: Well, then we make -- this request we make to DMS as we normally do. They're going to ignore it; right?

MS. SCHUSTER: Right.

MR. SHANNON: I mean, there's not a choice. But going forward, I think every recommendation runs through the MAC to DMS. It slows down the process, but they don't respond now; right? Because this one I think we've got to see if we can get on the agenda.

MS. SCHUSTER: For September.

PARTICIPANT: Are we more than two weeks away from the MAC meeting, is that why we can't get on --

MR. SHANNON: No.

PARTICIPANT: -- their agenda?
MR. SHANNON: No.
MS. SCHUSTER: No. We're still -- they're supposed to turn in their agenda two weeks in advance, and so they -- they're meeting September 23rd.
MR. SHANNON: 26th.
MS. SCHUSTER: Or 26.
MR. SHANNON: 26th.
MS. SCHUSTER: So we're okay. I just have never gone directly to the MAC and requested that an -- that an item be put on there.
PARTICIPANT: But I think it's because you aren't part of the MAC. Because we're hearing dental issues all the time, because we've got a dental rep right here on the MAC.
MS. SCHUSTER: Yeah.
MR. SHANNON: Yeah, we don't have a person on the MAC.
PARTICIPANT: -- hearing ophthalmology because --
MS. SCHUSTER: Yeah.
PARTICIPANT: -- there's an

ophthalmologist. We're hearing nursing homes --

MS. SCHUSTER: I bet the --

PARTICIPANT: -- so I think it's because you're not part of the MAC --

MR. SHANNON: I think --

PARTICIPANT: -- but that's why our -- that's what we're supposed to do, I think --

MS. SCHUSTER: Yeah. Yeah.

PARTICIPANT: -- according to their responses.

MR. SHANNON: That's the vehicle.

MS. SCHUSTER: All right. So that's a good point. I mean, I don't -- I certainly don't mind asking her and telling her that this is really critical because these regs are in effect.

MS. GUNNING: And especially the psychiatry or the specialties in SUD and to be a provider you have to have that designation as an addictionologist.

MS. SCHUSTER: Yeah. I mean, there's so many problems with these -- with these regs. But do we in addition want to make

any specific recommendation? I guess I'd like to have something on record in case --
MR. SHANNON: Yeah. No. Yeah, yeah.
MS. SCHUSTER: I can't do it or --
PARTICIPANT: You had very clear recommendations in what you submitted.
MS. GUNNING: Yeah, you did.
MS. SCHUSTER: Yeah.
PARTICIPANT: And what we're asking you, please do this.
MS. SCHUSTER: Okay.
MR. SHANNON: Yeah. And my concern is DMS is going to say we received those comments, thank you.
MS. SCHUSTER: Yeah, we've already received them.
PARTICIPANT: We've already received them.
MR. SHANNON: That's why the MAC says, I want to hear this issue.
MS. SCHUSTER: Okay. I got you. All right. Can we get a motion that I will write up those specific recommendations that we have all talked about and add those in our recommendations?
MR. SHANNON: I move that, yes.

MS. SCHUSTER: How's that for a vague motion? You move that, Steve? Mike, Val?

MR. BARRY: I'll second -- I'll second that --

MS. SCHUSTER: All right.

MR. BARRY: -- whatever that is.

MS. SCHUSTER: All right. All in favor?

PARTICIPANT: Aye.

MR. BARRY: Albeit.

MS. SCHUSTER: Albeit.

MR. SHANNON: Do we have a second motion that we will request of the MAC to put the BHSO regulation on the agenda for public discussion on September 26?

MS. MUDD: I'll move it.

MS. SCHUSTER: Yeah. Val will move that. Second?

MR. BARRY: Second.

MS. SCHUSTER: Second. All in favor.

COMMITTEE MEMBERS: Aye.

MS. SCHUSTER: Okay. All right. Thank you very much.

MR. BALDWIN: Before we -- before we move off that -- those regs, can I just comment on a couple of things?

MS. SCHUSTER: Yeah.
MR. BALDWIN: Process-wise -- and I think it's good to get this on the agenda sooner rather than later if we can, because they're E-regs.
MS. SCHUSTER: I know. July 1 --
MR. BALDWIN: They're also going -- but they're also going through the process. But after we make all these comments, they're -- the Cabinet is required to do a Statement of Consideration within 30 days and they can request the 30-day -- another 30-day delay.
PARTICIPANT: And they've already said it's likely they won't be out until October because there's so many --
MR. BALDWIN: So many, yeah.
PARTICIPANT: -- comments they have to respond to.
MR. BALDWIN: So it will probably be longer than that. And then it goes to the administrative regulation review subcommittee --
MS. SCHUSTER: Right.
MR. BALDWIN: -- to review, which it

doesn't have to say -- this is their right. It doesn't have -- they don't necessarily approve it.

MR. SHANNON: No.

MR. BALDWIN: There's been some legislation in past years worked on that, but none of those bills ever passed. So there is an opportunity -- point being, your point, there is an opportunity for a public hearing on the regulation --

MS. SCHUSTER: Yeah.

MR. BALDWIN: -- at that committee, whenever it takes place, which sounds like it will probably be November.

MR. SHANNON: Yeah, I think November.

MR. BALDWIN: November. And then after that it goes to the subject matter committee, which will be held at Department of Family Services on this one. There's opportunity to comment. Although a reg rarely gets that far to the health and welfare. But sometimes the legislators, on an administrative reg, will tell the Cabinet, clearly, you don't have this right yet, go back and work on this. We'll --

MS. SCHUSTER: Yeah.
MR. BALDWIN: -- we'll defer this reg another month and come back. So there's -- I'm just pointing out that there are other steps in the process that if they -- if they just come back with a statement of consideration and say thanks, for your input, we're keeping it as is, you know --
MS. SCHUSTER: Yeah, I think --
MR. BALDWIN: -- there's other venues.
MS. SCHUSTER: -- we flood KARRS members with exactly the same.
MS. MUDD: If we're supposed to go to --
MR. BALDWIN: And that is more of a -- I'm sorry. That is more of a hearing where the legislators can ask questions.
MS. MUDD: Right, right.
MR. SHANNON: Yeah, there's a discussion.
MR. BALDWIN: A discussion --
MS. MUDD: And we can talk to legislators ahead of time --
MR. BALDWIN: Yes.
MS. GUNNING: Yes.
MS. MUDD: -- and let them know what our issues are.

MS. GUNNING: Yes.
PARTICIPANT: In fact, that was my next step -- my next step of the strategy. I mean, we've gone -- taken these steps and that was going to be my next step, was to --
MR. BALDWIN: Yeah.
PARTICIPANT: -- ask for a meeting with -- of course, my legislature is Mary Lou Marzian, so it's not -- I'm preaching to the choir --
MR. SHANNON: And I think she's on -- she's on the committee.
MS. GUNNING: She's on that committee.
MR. SHANNON: That's who you got to focus on, the committee members.
PARTICIPANT: One of the things you want to do is, when you get the Statement in Consideration is to see how the Cabinet responded and if they made a favorable change --
PARTICIPANT: They may make some changes.
PARTICIPANT: -- usually before you go to ARRS or legislators. That's just usual.
PARTICIPANT: One question I had, Sheila,

is can they withdraw an E-reg? Because I was just wondering if there's merit in asking for them to withdraw the E-reg and back up a bit.

PARTICIPANT: Yeah, that would be great.

PARTICIPANT: Because it's thrown the whole everything in turmoil.

PARTICIPANT: Yeah, they had no idea what they were doing.

MS. SCHUSTER: Yeah.

PARTICIPANT: I mean, and even when you write a reg, if you're going to have it be effective the day you file it because it's an E-reg, at least provide for some as of October 1st -- you know, delay the implementation so people can come up to par with the new requirements, because --

PARTICIPANT: They're not really licensed --

PARTICIPANT: We're not in accordance with the reg right now.

PARTICIPANT: None of us. No one. Because they're -- all of their payments will be denied --

MR. SHANNON: Yeah.

PARTICIPANT: -- because they're not appropriately licensed.

MR. BALDWIN: Yeah, there's one -- there's some E-regs you can do emergency regs -- licensure like you said -- but everybody that had that license is out of compliance as soon as -- well, I guess you can withdraw an E-reg.

PARTICIPANT: I was all upset about the webinar and not knowing about the webinar. Because if people didn't know about it, then they didn't know to get online and they had to be online and registered before July 1st. And now it's -- I'm not sure if they all registered as one, two and three or just one, three. I don't even know now that I've seen the regs and read through them.

MS. SCHUSTER: All right. Do we want to ask for the E-reg to be withdrawn?

PARTICIPANT: Yeah, all of them.

MS. SCHUSTER: Okay.

MR. BALDWIN: Let the ordinary regs go through the process.

MS. MUDD: Including the OIG reg.

MS. GUNNING: Yeah, the OIG one was confusing, too.
MS. MUDD: I just thought of that one at the last minute.
MS. SCHUSTER: Well, Valerie --
MS. GUNNING: But that would put you out of compliance with KARP, right?
PARTICIPANT: No, no. That was is -- that was in the --
MS. GUNNING: That was the other one. I'm sorry. That was a screening assessment one.
MR. BALDWIN: E-regs, they're just good for 180 days?
MR. SHANNON: Yeah, they're just good --
MS. SCHUSTER: Yeah.
MR. SHANNON: -- the end of the year. The other ones have to be implemented by the end of the year.
MS. SCHUSTER: Yeah.
PARTICIPANT: Yeah, you need to make sure that if you're going to request Chapter 15 regs be withdrawn, that the OIG one be withdrawn.
PARTICIPANT: Was it an E-reg or an

ordinary?
PARTICIPANT: It was an E-reg also, I think.
MS. SCHUSTER: All right. Okay. On to the next thing.
MS. MUDD: I have a -- I have a question.
MS. SCHUSTER: Oh, yeah.
MS. MUDD: If we're supposed to be sending our recommendations to the MAC and not to DMS, why is DMS responding, period? I mean, you understand what I'm saying?
MS. SCHUSTER: Yes.
MS. MUDD: I mean, why don't we get a response from --
PARTICIPANT: Because we do go through the MAC.
MS. MUDD: -- response from the chair?
MS. SCHUSTER: Because we are -- we are sending our recommendations to DMS, but the only way we can get them there is through the MAC.
MR. CALLEBS: And they respond to the MAC.
MS. SCHUSTER: And they respond -- well, actually, no, they don't --
MS. MUDD: They responded to us.

MS. SCHUSTER: -- which is interesting, they responded to us.
MS. MUDD: That's why I'm confused.
MR. CALLEBS: Well, this responds to the MAC. Specifically, it's the number one "to", and then underneath. It is a response to the MAC. The MAC sends the recommendations up to Medicaid. And then Medicaid -- if they get a written recommendation from the MAC, it's my understanding they must respond in writing to the MAC, which they did, and also the TAC, but primarily to the MAC, I think, as a courtesy to the TAC.
MS. SCHUSTER: Yeah, right. Because --
MR. CALLEBS: So they are consistent.
MS. SCHUSTER: -- their response goes to the MAC and to our TAC.
MR. CALLEBS: So they have responded according to the designated process, but, again, good point, not much a response in some cases.
MS. SCHUSTER: Yeah.
MR. CALLEBS: But they would deem this as being in compliance with their

responsibilities, because they responded appropriately to the MAC.

MS. SCHUSTER: Exactly.

Fareesh, I'm delighted that you're here, because you raised a question about formulary changes. Do you want to talk about what your concerns were?

DR. KANGA: I didn't know that I would be able to make it today, so --

MS. SCHUSTER: I have your -- I have your e-mail if you want to.

DR. KANGA: I don't know what I did this morning, so...

MS. SCHUSTER: Now speak up so everybody can hear you.

DR. KANGA: Oh, okay. So what we're running into is --

MS. SCHUSTER: You want to introduce yourself since you weren't here for introductions.

DR. KANGA: It's getting worse and worse. This is the Tuesday that turns into a Monday.

I am -- I'm Fareesh Kanga. I'm a psychiatrist in Lexington. I work at

HealthFirst and the University of Kentucky. And I -- and I'm also with NAMI Lexington. And I have been having issues recently, me and some of the people that I supervise, because things that are on formulary, then go off formulary and we're not really notified, or, for example, apparently Vyvanse was taken off the preferred list of medications. And so it was preferred, so they were asking us to use it. Then they took it off, which is fine. But then they wanted us to use two other medications before we could go back to the Vyvanse, even with a prior authorization. The child had been on it for like years and they wouldn't even give a seven-day refill as we try to sort of figure it out, like an emergency fill. So like -- and this is right at the start of school. So then kids go without medication right at the start of school. I mean, it's like -- for those of you have ever watched a kid tank at school because of medication and the lack thereof, it's really heart breaking. I mean, these are like kids, but, you know.

And then my adult nurse practitioner said that Invega Trinza, the long-acting injectable, had been removed and there was no notification of that. And they were told that they just want you to use the oral medication like Invega oral. I mean, it's not even -- does not even compare. And for those of you who see patients on long-acting injectables, that's life-changing medication. Those are people going back to work, getting their lives back, so on and so forth. So those were my -- those were the two that we came up with in August that were just --

MS. SCHUSTER: So I asked the MCOs to provide us with information about the formulary changes. And why don't we start over there with Passport.

MS. McKUNE: We have had two changes during this time period. So one was a formulary change in May in which four members who would be new to being prescribed Vyvanse it became non-formulary. For those that were existing, already on, it was continuing treatment, they were grandfathered. And

then we have added a new to market drug, the Bravado, in May.

MS. SCHUSTER: So I think, Liz, that back to Kanga's experiences that those patients were not being grandfathered, is that your --

PARTICIPANT: Is there a time frame on grandfathering?

MS. McKUNE: If they were continued in -- if they were continuing in treatment, if they had been prescribed right before then. If there was a gap in treatment, they would have to go through a process, but if it was continuing --

DR. KANGA: And those changes don't affect grandfathering, right? I mean, they shouldn't -- doesn't make sense. But one of the other things we do, over the summer I'll try to lower doses of medication because the kid isn't in school anymore. And sometimes we'll even go off medication, if the kid can handle it, and we'll restart medication end of summer. And so if that's what's being called gap in treatment, we will still have appointments and I'll check

in on them and so on and so forth. If they're off medication and they go back on it after a month or two, that's a good thing to do especially children gaining weight or...

MS. McKUNE: Our pharmacist isn't here, so I don't -- I don't know the answer to that. But we do have an appeal process and I think you could easily make that argument and it sounds -- you know, so we're continuing the care, I would think it would be supported. I don't know for sure, but...

DR. KANGA: Well, I mean, I wrote that -- I wrote her after we had done the prior authorizations. We had done all of that. They weren't even letting us have anything. So this child is without medication. We can see them -- I mean --

PARTICIPANT: Without any medication?

DR. KANGA: Well, I mean, we can write it, but we want to see the kid before we just start him blindly on a new medication. You know what I -- that's how we try to do it.

MS. SCHUSTER: So Passport changed Vyvanse,

but only for new patients essentially?
MS. McKUNE: Yes.
MS. SCHUSTER: You're grandfathering the other ones?
MS. McKUNE: Yes.
MS. SCHUSTER: There should be some mechanism if a kid is titrated off or has a drug holiday, or whatever we want to call it in the summer. As long as the child is still in treatment, they ought to be able to get back on the Vyvanse.
MS. McKUNE: Right. There's an appeal process.
MS. SCHUSTER: Okay.
MS. McKUNE: And the spirit and intent is to continue children. It's not starting brand-new medications that you would start with Vyvanse.
DR. KANGA: This is not new. This is not a start from scratch.
MS. SCHUSTER: Okay. So, obviously, there is some slippage here. So what do you suggest that Dr. Kanga do?
MS. McKUNE: I can give you my card at the end and we can reach out to our Director of

Pharmacy.

DR. KANGA: Okay. That sounds good. Thank you.

MS. SCHUSTER: All right. Abner, did you have any questions about Vyvanse --

DR. RAYAPATI: No.

MS. SCHUSTER: -- and that situation?

Let's see. Who else do we have MCO wise? Aetna?

MR. JOHNSON: Yes.

MS. SCHUSTER: Yes.

MR. JOHNSON: So our pharmacist did provide us a list of changes that -- that have occurred since 2019 with the formulary. And she also advised that there's access to that on our website as well to look at those changes. And I have a handout for anybody that wants to know what those changes are. And she actually put in parenthesis what was done, whether it was removed, if there was an age limit requirement change or anything like that. So does anybody want a copy? I can pass them down.

MS. SCHUSTER: Yeah, give -- give Dr. Kanga

one for sure.

MR. JOHNSON: Okay.

MS. SCHUSTER: And Dr. Rayapati over here would be great.

Do you want one, Marc? Marc from Pathways?

MR. KELLY: I got one.

MS. SCHUSTER: She sent me one. Yeah. Thank you.

Anybody else? So this is a fairly long list. It is helpful because it gives the time frame and it talks about what the changes were, whether they were, you know, by age, by dosage or whatever. I will also -- because I think I have this electronically.

MR. JOHNSON: Uh-huh (affirmative).

MS. SCHUSTER: So if anybody needs it, if anybody else needs -- Marc, do you want one?

Okay. Thank you very much for that.

MR. JOHNSON: No problem.

MS. SCHUSTER: Who else do we have?

PARTICIPANT: Anthem.

MS. SCHUSTER: Anthem. So what's your

story, Anthem?

MR. RUDD: So my name is Andrew Rudd. I'm the Pharmacy Director for Anthem. So I wanted to just talk briefly. You should be getting -- Sheila, you should be getting a update, a printout like what Aetna provided, that breaks it down per quarter, just kind of a high level. We had six quantity limit changes. Four of those were updates to existing limits; two were new and those were because they were new drugs. Quantity limits are within the dosing limit of the package label, so they're just not indiscriminately determined. There were six PA changes. Four of those were updates and then two were -- two new-to-market drugs, one of those being Spravato. And then the other was Evekeo VT, was added PA. Basically, it was looking at diagnosis of ADHD and then individual of six years of age or old other, which is verbatim out of the package label.

There were three step therapy updates, and it was basically adding new drugs within that class to those updates. And that

information is available on the provider portal as well.

MS. SCHUSTER: And then you're going to send me that?

MR. RUDD: Yes, ma'am.

MS. SCHUSTER: Okay. Thank you.

And CareSource?

MR. VENNARI: Humana CareSource, yeah. My name is Joe Vennari, Pharmacy Director. We had only two changes. The Spravato, the same as Anthem. We put PA on that for the new drug. And age limit, it increased to 18 for Clozapine. That's it. And I can send you those two changes.

MS. SCHUSTER: Okay. What about this change in the Invega Trinza for the long-acting injectable to a change to requiring or requesting the oral medication instead?

MR. VENNARI: Are you talking about Humana CareSource specifically here?

MS. SCHUSTER: That's what you had, Fareesh? You thought it was Humana CareSource? Does that not sound familiar?

MR. VENNARI: No. I can take a look at

that.
DR. KANGA: That's an adult issue, so it's not something I have seen.
MS. SCHUSTER: Okay. Maybe you could give Dr. Kanga your contact information; would that be all right?
MR. VENNARI: That would be fine.
MS. SCHUSTER: Because she had that question.
MR. SHANNON: But did any of the others have that issue, because we -- maybe it's a WellCare issue.
MS. SCHUSTER: Nobody else had changed -- none of the other MCOs changed the Invega Trinza? Yeah, I wonder. And WellCare is not here. So let's find out, but let's go on -- why don't you go on and get -- before you leave today.
DR. KANGA: I can find --
MS. SCHUSTER: Okay. And I'll get in touch with the WellCare folks and see what we can find out.
DR. KANGA: -- look into it.
MS. GUNNING: Sheila?
MS. SCHUSTER: Yeah.

MS. GUNNING: I think this is a good opportunity to reiterate how their P&T committees work. And, I mean, when I look over this list from Aetna, it's a lot of drugs, it's a lot of changes, you know, two and a half pages.
MS. SCHUSTER: Over the course of nine months --
MS. GUNNING: Yeah.
MS. SCHUSTER: -- or something.
MS. GUNNING: But, I mean, still we have no input really into that much at all.
MS. SCHUSTER: And is the State P&T Committee still meeting?
MR. SHANNON: Yes.
MS. SCHUSTER: It is?
MR. SHANNON: Yeah. I mean, I see it on the agenda, so...
MS. SCHUSTER: Okay.
MR. SHANNON: Yeah, we've made comments repeatedly that --
MS. GUNNING: Yeah, I know.
MR. SHANNON: -- they ought to review. The state one ought to review, just review. It is a forum we can all go to, but that's

never gone anywhere.
MS. MUDD: I mean, we've got -- we've got lithium on here. Changes for lithium? That seems a little crazy to me. I mean, some of the other ones, you know, that I try to keep up on the generic forms, but lithium? Really?
MS. GUNNING: Well, the thing is, you know, this -- this can all happen, once again, in this, you know, vagueness of a black hole and nobody has any way to counter it. In the old days if we knew that they were going to be taking a long-acting injectable out of circulation or not allow it or whatever without a bunch of hoops, we would be up there raising cane. And, I mean, long-acting injectables -- our state and our department and our Cabinet keep saying they want state of the art. They want --
PARTICIPANT: Or that it works, it works.
MS. GUNNING: -- to save money. They want to save lives. They want people working. But they're taking away everything that we have that's providing that.
MR. KELLY: Well, we're talking about best

practices, once again.
MS. GUNNING: Again.
MR. KELLY: Like we need regulations and formularies that reflect best practices.
MS. GUNNING: That support what they talk about.
MR. KELLY: That's what we need.
MS. GUNNING: Their actions don't match their words.
MS. JOHNSON: Medicaid's actions don't match.
MS. SCHUSTER: Well, we have --
MS. GUNNING: Medicaid's actions don't match behavioral health words, just like Ramona said. So, once again, we're like kind of all this stuff happens in the cloak of darkness. And then even prescribing MDs don't find out until they go to do it.
DR. KANGA: That's a lot of our time. That's a lot of my nurse's time, too.
MS. GUNNING: Talk about that a little bit more, Fareesh, please? Just about how much time they -- they think that changing one or two of these drugs is no big deal, but tell them the reality.

DR. KANGA: Hours. Those PAs are hours and hours. I mean, I don't -- I'm not exaggerating. I have myself -- when my nurse is out, I do my own PAs. And we're talking two and a half hours. We're talking a process in one day; we're talking a process that can continue over two weeks, if you have to get into appeals. And I'm in clinic. I mean, I've got other people to see and I'm -- you know, I'm backed up and I'm on hold and I just can't get through. Or you're -- you know, you're told A person tells you X, and then B tells you Y. And, I mean, it's just you go through 15 different people before you get anywhere. It's hard -- I mean, it sounds like just submit this paperwork. It is not that simple.

MS. SCHUSTER: It's not that easy.

MS. GUNNING: And this is 51 changes. Now, you know, again, I'd like to go back to even not knowing about where the regs are buried and where the hearings are buried in the regs and all that kind of stuff. All of us are busy doing other things besides

just combing the regs and the e-mails and looking for when a webinar is going to be or when a hearing is going to be or when to file your comments by. I mean, I'm not sitting there. I'm out in the community. I'm not sitting at a desk. I don't have an administrative assistant that sits there and combs through this stuff for me saying, oh, you better respond to this.

MS. MUDD: I'm a little -- there's -- I mean, the -- Clozapine is limited as it is. I think that's interesting that Clozapine is on this list. That there is a quantity level limit when -- I mean, you know, Clozapine, there's a -- there's a quantity limit on it already.

DR. KANGA: And there's -- I mean, Clozapine, you're monitoring it pretty closely, not just willy-nilly throwing Clozapine --

MS. GUNNING: I mean, we don't want anyone to get a granular psychosis, so we're not going to have them out there taking pill bottles full. But 51 changes. Oh, by the way, here's our 51 changes.

MR. JOHNSON: I know that -- I understand the conversation and frustration there. I just want to -- I did have the opportunity to be on a conference call with the list, since we did provide it. I just want to say the changes that occurred with that were based on best practices and based on a lot of meetings, I guess --

MS. GUNNING: But meetings with who?

MR. JOHNSON: Meetings with people who are on like -- they have a committee. And I cannot think of the name of it, but I can get that to you.

MS. GUNNING: P&T Committee?

MR. JOHNSON: That they sat with and -- and they do the recommendations from the FDA, VA those type of guidelines that are coming down for those changes. And any -- our pharmacists let me know that any negative impact that it could have to a patient or member regarding a drug change, that they're giving 30-day notice to the provider and to the member before that change becomes effective.

MS. GUNNING: Did you know about all this?

DR. KANGA: No.

MS. GUNNING: What? No?

DR. KANGA: No.

MS. SCHUSTER: I think the problem is that there was a time when we had a single formulary that was the Medicaid formulary. And we had a P&T Committee and we worked very hard. In fact, passed legislation to put an additional psychiatrist on that. So we had two psychiatrists, one from the community and one from one of the universities, because we wanted to be sure that we had input. And we used to storm those meetings. I mean, they -- you know, you had to register weeks in advance and all this stuff. But we used to be there and speaking up about the impact of some of these changes. And it's all changed because every MCO has its own formulary.

And we have recommended, I don't know how many times, that Medicaid go back to a single state formulary, which all of you-all MCOs would be fighting, jumping up and down and saying, no, you don't want to do that. The fall-back recommendation, which we also

made a number of times, was that the Medicaid P&T Committee should review these changes that were being made like the changes that we had asked for here, and have an opportunity at a public -- at a more public hearing to post those changes and get input from practicing psychiatrists who are in the field, psychiatric nurse practitioners who are seeing patients --

MS. GUNNING: Patients --

MS. SCHUSTER: -- every day.

MS. GUNNING: -- patients and their families.

MS. SCHUSTER: Patients and their families and -- and advocates.

MS. MUDD: I mean, we've had this problem since day one when the -- the MCOs walked in the door. You know, I mean, they told us we're going to grandfather people in, you know, it's going to go fine. And, bam, it's just been a mess.

MS. SCHUSTER: Yeah. I mean, I can think back to the summer of 2011 when we had a -- we were in the biggest room you could have up here. It was standing room only. And

we had the three MCOs up here. And they swore to us, on a Bible, that people would get their medications. They would get grandfathered in on their medications; they would never be taken off those medications.

MS. GUNNING: And we'd have -- and we'd have representation.

MS. SCHUSTER: Yeah.

MS. MUDD: And it was just a flat-out lie.

MR. SHANNON: We didn't know what grandfathered meant.

MS. GUNNING: I do remember that.

MS. SCHUSTER: Yes, yes, that's right, we didn't know what grandfathered meant.

Do we want to go back and make a recommendation again just for the hell of it, just to not let this --

MS. GUNNING: Again, I think using the process that Steve outlined, get it on the MAC and make it to the MAC and --

MS. SCHUSTER: And say that we -- that we request that the --

MR. SHANNON: Yeah. It may slow it down, but we're not getting a response from Medicaid.

MS. GUNNING: Yeah.
MS. SCHUSTER: That the Medicaid P&T Committee would review, at least annually, if not every six months, changes in the formulary for the psychotropic meds.
MS. GUNNING: Well, especially when there's going to be so many.
MS. SCHUSTER: Okay. Somebody want to make that recommendation?
MR. SHANNON: I'll so move.
MS. SCHUSTER: All right.
MS. MUDD: Second.
MS. SCHUSTER: All right. All in favor signify by saying aye.
COMMITTEE MEMBERS: Aye.
MS. SCHUSTER: Okay. Thank you for bringing up those issues, Fareesh.
DR. KANGA: Thank you all for getting to it.
MS. SCHUSTER: Because if we don't hear from the practitioners -- and I know you don't have enough time to send e-mails, but I'm trying to take them -- trying to take them and go to the next level with them.
DR. KANGA: I mean, I'm glad -- anything to

make a day in the life of all of us doing this work easier.

MS. SCHUSTER: So that people get what they need when they need it without a lot of hassle.

DR. KANGA: Right. Or I'll just stop getting Board certified.

MS. SCHUSTER: Well, don't do that.

DR. KANGA: Well, apparently, it doesn't matter.

MS. SCHUSTER: So, Kathy, this next item is yours, and DMS did not reply to it. Kathy had asked about the timeline for implementing single credentialing entity, which was House Bill 69 in 2018 and House Bill -- Senate Bill 110. Do you have any updated information?

MS. ADAMS: I've been trying for months. I've sent it to the DMS issues. I'm a rule follower, except when it comes to driving the speed limit, maybe.

MS. SCHUSTER: Let's not -- you're on the court record here. You know, be careful. You didn't get her name, right? (Laughter)

MS. ADAMS: So, yeah, and no response, no

response. I've sent another one. I'll get a response back that says, oh, we'll research this. And it's like this is a big Medicaid -- should be a big Medicaid issue.

MS. SCHUSTER: Well, this ought to be a big MAC issue, because it's --

MS. ADAMS: Why can't you tell us --

MS. SCHUSTER: -- it's every, professional; right?

MS. ADAMS: Yeah. And so, again, sent another one just -- I think right before I sent it to you, I sent another one and still no response, no update.

MS. SCHUSTER: All right. Yeah. Bart?

MR. BALDWIN: I thought it was going to be July 1 next year when everything else gets rolled in, the new contracts. But maybe I just -- maybe I just assumed that. But if you're not getting a response --

MR. SHANNON: She addressed this in the committee last week.

MR. BALDWIN: I mean, that was months ago. It could change.

MS. ADAMS: But that was a verbal thing --

MR. SHANNON: Yeah, I know, I know.

MS. ADAMS: -- that she said at one of the hearings. I believe what she said was that, I've got my chief somebody --

MR. SHANNON: Yeah, that's right. Yeah.

MS. ADAMS: -- solely assigned to this issue and it's taking much longer than we thought, and we're going to do an RFP for the single credentialing agency.

MR. SHANNON: That was...

MS. ADAMS: Okay. So what's the timeline?

MS. SCHUSTER: Right.

MS. ADAMS: When -- when can we expect this to happen?

MR. SHANNON: Yeah, the Chief of Staff is going to address this issue, Medicaid Chief of Staff. That's her task.

MS. SCHUSTER: Who is that?

MR. SHANNON: I wrote her name down somewhere.

MR. BALDWIN: Yeah.

MR. SHANNON: She's recently hired.

MR. BALDWIN: Recently -- yeah, I seen her in a committee hearing. I didn't know her before.

MS. SCHUSTER: Do we want to ask the MAC to

put that on their agenda? Because that's actually a MAC issue.

MS. GUNNING: I think it's a MAC issue.

MS. SCHUSTER: It really is.

MS. GUNNING: It's a MAC issue.

MS. SCHUSTER: All right. Valerie, you want to make that motion?

MS. MUDD: All right.

MS. SCHUSTER: Second?

MR. SHANNON: Second.

MS. SCHUSTER: Steve. All in favor signify by saying aye.

COMMITTEE MEMBERS: Aye.

MS. SCHUSTER: All right. Boy, Beth's going to be really excited when I call her with all these things.

MR. BALDWIN: Going to take over their agenda.

MS. SCHUSTER: Yeah. Update on Kentucky Health. October 11th is the day of the oral arguments in front of The Court of Appeals, the Federal Court of Appeals on the Medicaid waiver. So that also is the day of the Kentucky Voices for Health annual meeting, which you-all are invited

to, which will be in Lexington. It's going to be a good program. But we will have eyes and ears in D.C. at that hearing, and I'm sure we'll be getting little text updates and so forth.

MR. SHANNON: Live streaming.

MS. SCHUSTER: Live streaming, yeah.

PARTICIPANT: When did you -- what was the date, Sheila?

MS. SCHUSTER: October 11th, so Friday. And I think they start at either 9:00 or 9:30.

In your handout materials, you know, the KI-HIPP is still going forward. That's the program where Medicaid folks are encouraged right now to take advantage of their employers' insurance. And they've sent letters out to about 35,000 people on Medicaid, and another group -- another group of 35,000 letters is supposed to go out in September. Kentucky Voices for Health, Kentucky Center for Economic Policy, and Kentucky Equal Justice Center have done an analysis of KI-HIPP, which is this front and back, which really should have you -- have

people pause about getting into that program.

As far as we can tell, people are going to have to pay the premium themselves and then get reimbursed, which is certainly a problem for most of our folks on Medicaid. Also, if they see a provider who is not a Medicaid provider, even though they are covered by the employer's insurance, they are responsible for all the cost sharing. And those copays and deductibles and so forth are going to be a whole lot higher than they are on the Medicaid program. We also are not sure what happens if the person loses their Medicaid coverage, whether they stay on the employer's insurance or not. So there's a whole transition piece here that we have concerns about. So we're suggesting -- and I don't know if any of you had -- Kelly, have you had people, or Val, come with these letters and ask you about them?

MS. GUNNING: No.

MS. SCHUSTER: Okay. So I have --

MS. GUNNING: That's scary.

MS. SCHUSTER: Yeah, I mean, they're --
MS. GUNNING: They probably don't even look at them.
MS. SCHUSTER: Well, another 35,000 letters are going to go out. So I just suggest that you really have people be careful.
MS. GUNNING: Because usually when they get them, if they think it's something to do with terminating their benefits, they'll bring it to us.
MS. SCHUSTER: Yeah.
MS. GUNNING: I haven't had that one, have you?
MS. SCHUSTER: It's not mandatory yet. There is some question about whether they're going to try to make it mandatory. Right now it's voluntary. And I think they said 179 people have signed up, so, obviously, there's not been a huge uptick. But if they get frustrated with that, my concern is that they might start making it -- try to make it mandatory, which is really going to be a problem for our folks.
Anything new on the impact of copays? Yeah, Bart?

MR. BALDWIN: Yeah, just to comment on the --

MS. SCHUSTER: KI-HIPP?

MR. BALDWIN: Yeah.

MS. SCHUSTER: Yeah.

MR. BALDWIN: I went to a couple of meetings on this and was trying to dig down why would anybody do this? Why? What's the benefit? Because, I mean, your copays stay at the Medicaid copay. So you don't go to the health -- the commercial health insurance, because -- I mean, we all know that going off Medicaid onto commercial health insurance is not a cost neutral event.

MS. GUNNING: No.

MR. BALDWIN: I mean, it's much, much more costly --

MS. GUNNING: Yeah.

MR. BALDWIN: -- to be on commercial -- any type of plan. But you keep your Medicaid copays. But, you know, really, the only thing I found, unless you just really get a huge promotion, you know, you can go off Medicaid eventually. You're making a lot

more money because of the benefit cliff. But if there's potential to get other members of your family covered through this. So if you have a child that's on Medicaid and -- for diagnosis reason, I assume, but you can't -- your other members of your family are not on any -- don't qualify for Medicaid or can't afford the commercial plan through an employer, then could potentially get them essentially covered -- the whole family covered under Medicaid through this. They pay -- Medicaid will pay the premium for the whole family if its cost -- if it meets their cost --

MR. SHANNON: If it's cost effective for Medicaid.

MR. BALDWIN: -- if it's cost effective for Medicaid. And if you have a really high needs, high-utilizer child, then that could potentially still be cheaper for them to pay the premiums versus those services. I know that gets into the weeds, but I was just trying to dig in what -- you know, like you said, why would someone take on

the responsibility of --
MS. SCHUSTER: Right.
MR. BALDWIN: -- higher -- high risk, you have to -- you know, it's riskier in a sense. You have to pay the premiums and get reimbursed, which that's a problem for anybody, especially if you're at that income level.
MS. SCHUSTER: Right.
MR. BALDWIN: So I was trying to dig down, what could be the potential benefit? That's the only thing I could -- which could be -- for some families, could be a really good thing.
MS. SCHUSTER: Medicaid is arguing that it expands the network for the individuals, because they now have access to non-Medicaid providers who are covered by the employer's insurance plan.
MS. GUNNING: Not fully probably.
MS. SCHUSTER: Well, except that there's a cost to it.
MS. GUNNING: Yeah, there's a cost.
MS. SCHUSTER: So I'm not -- I'm not so sure that that's -- how much of a benefit

that is.
MR. BALDWIN: Yeah, but I think --
MS. SCHUSTER: Is that your understanding, too?
MR. BALDWIN: Yeah, yeah, I think --
MS. SCHUSTER: I mean, that's Medicaid's argument that the people --
MS. GUNNING: That's the risk, though, for the people.
MS. SCHUSTER: -- that the people would have a greater range of providers. I don't think -- I don't think that's true on the behavioral health side, quite frankly.
MR. BALDWIN: No, I wouldn't think so. Well, and they did say that in Kentucky -- which this number surprised me was this high, but they said 92 percent of providers in Kentucky are Medicaid of all the --
MS. SCHUSTER: I absolutely do not believe that.
MS. GUNNING: No freakin' way. No freakin' way.
MR. BALDWIN: I --
MS. SCHUSTER: I have heard that, too.
MR. BALDWIN: Because that was --

MS. SCHUSTER: Not in dentistry, not psychiatry.
MR. BALDWIN: I thought that would be 60 percent or 70 percent, so...
MS. GUNNING: Ain't no damn way.
MR. BALDWIN: Yeah. So...
MS. SCHUSTER: You know, we're hearing more and more, even family practice physicians --
MR. BALDWIN: Yeah.
MS. SCHUSTER: -- who are not taking Medicaid. So to say that 92 percent of providers are Medicaid providers is --
PARTICIPANT: Of all providers?
MS. SCHUSTER: Of all providers.
MR. BALDWIN: Not just behavioral health. Yeah, I think that's --
PARTICIPANT: No.
MS. SCHUSTER: It's certainly not true of psychology, I'll tell you that.
MS. GUNNING: No, absolutely not.
MS. SCHUSTER: Very few psychologists who opted into --
MS. GUNNING: Not true. Not dentists. We have one in all of Lexington.

MR. BALDWIN: Well, and I -- and I wonder if you just take in all providers, all primary care and hospitals and everything. By the time you get to -- the numbers work -- may work out to 92 percent, but we know for certain that psychologists in certain areas it's nowhere near that. So...

MS. MUDD: I'm looking at -- I've got -- it looks like a PowerPoint. I don't know where it came from. Oh, the Consumer Rights and Client Needs TAC. Now it says, Goals are -- designed to give Medicaid members the tools to afford quality comprehensive coverage in the commercial marketplace while also saving Commonwealth on healthcare expenses. Says this may make family coverage more affordable and may widen healthcare networks.

MS. SCHUSTER: Yeah.

MS. MUDD: There you go.

MS. SCHUSTER: That's what they're claiming.

MR. BALDWIN: So you have -- would potentially have access to providers you

don't on Medicaid.
MR. SHANNON: Not behavioral health.
MS. SCHUSTER: Yeah, not behavioral health.
MS. GUNNING: You will also have to be very careful to see only ESI providers who also accept Medicaid.
MS. SCHUSTER: Yeah.
MR. BALDWIN: The risk of it.
MS. GUNNING: Well, since 92 percent do that, it shouldn't be a problem.
MR. BALDWIN: I think in all this, the waiver and getting folks off of Medicaid and into a commercial plan, I just -- I mean, we're about 15, 20 years past the time where anybody thought commercial health insurance was good.
MS. SCHUSTER: Yeah.
MR. BALDWIN: That's just speaking from my own personal experience. I've paid more, got -- for less for every year for the last 20 years.
MS. SCHUSTER: Yeah.
MR. BALDWIN: So --
MS. SCHUSTER: No. I think that's right.
MR. BALDWIN: -- and that's not --

MS. GUNNING: I could buy a new house for what mine --

MR. BALDWIN: -- commercial insurance in general. I mean, everybody deals with that personally. But I don't know how that's a great move for anybody, but anyway.

MS. GUNNING: Although good game --

MS. SCHUSTER: Any new information on impact of copays? Anybody heard any stories? We're still trying to get the word out about people, you know, at or below 100 percent of the federal poverty level. The Public Assistance Reform Task Force meetings, we had a meeting this past month in August. You-all will remember House Bill 3 this last session that was going to drug test everybody who's going to get public assistance, was also going to require people to have picture IDs in order to use food stamps. We're going to put work requirements in for KTAP and some other programs.

And the bill didn't go any place, but now they have created this task force. It is co-chaired by Senator Stan Humphries from

far western Kentucky, representative David Meade from Lincoln County, who was one of the co-sponsors of the original bill. Has one democrat on it, Nima Kulkarni, who's a freshman Democrat, an immigration attorney from Louisville. Russell Webber from Bullitt County, Republican. Whitney Westerfield from Hopkinsville, the senator.

MR. BALDWIN: Max Wise.

MS. SCHUSTER: Max Wise, yeah, which is interesting, from Taylor County.

We did get Bill Wagner on it. Bill Wagner is the long-time head of the Family Health Center, the FQHC in Louisville. And he's been great at asking some really good questions on this thing. Also, Elizabeth Caywood, the Deputy Commissioner from DCBS, has been actually a very positive member. There's supposed to be a district court judge, but nobody's ever shown up in that spot.

We had some testimony. We were able to give testimony last August 19th about some of the problems with the recommendations, and I gave a long diatribe

about medically frail. And we really got some good -- I thought some good attention, particularly from Senator Westerfield, who's also the legal counsel for Pennyroyal Comp Care Center, who really was kind of exercised by the time we finished about all the problems with the attestation form and these kind of things and wants to add to the agenda having the Cabinet come and answer some of the questions that we had about the attestation form. So I thought that was progress.

They were supposed to meet on September 9th and they have cancelled that meeting. They're going to meet twice in October and then again in November. But there are a lot of people that are trying to make sure that the recommendations that come out of this are not as onerous as House Bill 3 was. Do you want to guess what the amount of fraud is in SNAP and TANF? One percent.

MS. GUNNING: I was going to say low.

MS. SCHUSTER: One percent. So they have done all of this legislation around, you

know, drug testing people and picture IDs and all this stuff for a one-percent fraud rate. And even some of the legislators who clearly came thinking they were going to go after waste, fraud and abuse were kind of like, what, one percent. So that was very positive, I thought. So we'll let you know when the next -- the next meeting is. I think it's -- I don't want to guess because I can't remember. It's like October 9th and then October 30th, but we'll let you know.

I mentioned the teleconferencing. I don't think that we need it because we haven't had any trouble getting membership here.

Mary, can you give us any update on redesign of 1915(c) waivers? Are you still on that committee?

MS. HASS: I'm still on that committee. I can't give you any -- I don't think it's going anywhere, because I know Johnny is on there, too. I mean, personally? This is my personal opinion. I think they're just wanting us to rubber stamp some things they

want to do. But I have seen nothing productive come out of it, other than they are doing some rate setting.

MR. CALLEBS: New rates coming out in the fall.

MR. SHANNON: Yeah.

MS. HASS: And so...

MR. CALLEBS: Don't hold your breath if you're a provider.

MS. HASS: The one gentleman felt positive on the rate settings. I don't -- again, I'm an advocate, so I really don't get into what providers are being paid one way or another. The ones that were on that seemed to think that it was positive from what I heard them say.

MR. SHANNON: Not everyone on it thinks that way.

MS. HASS: Okay. That's what I'm saying.

MR. SHANNON: Knowing someone who serves on it, that person has great reservations and is not permitted to give details. But I know it because I'm that person.

MS. HASS: But you're not -- are you on the big advisory or --

MR. SHANNON: No. I'm on the rate study.
MS. HASS: Okay. Thank you.
MR. SHANNON: My sense is that they have made tweaks around the edges. They've changed some programs; they've changed some definitions. Two waivers are seeing a fairly large reduction overall in terms of dollars, you know, close to 10 percent.
PARTICIPANT: Did he say reduction?
MS. SCHUSTER: Reduction.
MR. SHANNON: Yes, reduction. The cost --
MS. GUNNING: Ten (10) percent in each one, Steve?
MR. SHANNON: The category of the waiver is receiving about a 10 percent reduction. And there's six waivers, so four are not. It has to be budget neutral. So when they made changes, there essentially has to be losers if there's any winners at all, so -- but it's not going to be available, I don't think -- maybe October is when they're going to release it to you-all.
MS. HASS: So we have a meeting coming up on September the 12th --
MR. SHANNON: Okay. Maybe it's then.

MS. HASS: -- is the next -- is the next --
MR. SHANNON: Hopefully -- okay, you should see it then.
MS. HASS: But if you ask my general opinion, my general opinion, I do not see much good that has come out of it. You know, again a couple things that I had off -- you know, that I was concerned about, it's going back to give it to the comment line and have I gotten any --
MR. SHANNON: Right.
MS. HASS: -- comment back on the comments I made? No. So, again, I sit on the big committee, so -- I mean, I'm not overly enthused. Maybe after September 12th I'll be a little bit more enthused. But right now I just -- I just feel like it's rubber stamp and -- the one thing that I feel most negative about is that -- and I brought this up to two or three senators, is that the families that I recommended to be on -- someone like the case management, quality of care person directed, all of -- well, excuse me. Of the four families I recommended, three of them resigned just

because they felt like they were not being taken seriously. And these are people who have individuals accessing the Medicaid system. And these are people with very severe behavioral issues and brain injury on top. They're behavioral issues and brain injury issues. So that's what I'm most about. And I will bring that up on the September 12th meeting that I felt that, again, the families were really not taken seriously on the subcommittees.

MR. CALLEBS: One other big change, Sheila, around case management is that the case managers are going to be given the authority to prior authorize services, and care-wise remove from that equation, so taken out as the middle man. So when care managers go into MWMA and put in a plan, they will automatically generate PAs and be able to theoretically kind of streamline that --

MR. SHANNON: That should expedite the process.

MR. CALLEBS: -- plan approval so that you can access services and maybe decrease

potential for gaps in there. So I think most people say that's a positive move.

MS. SCHUSTER: Yeah.

MR. CALLEBS: With a lot of training upfront, make sure it goes well, but -- so that's coming as well by the end of the year --

MS. SCHUSTER: Okay.

MR. CALLEBS: -- with the case managers.

MR. BALDWIN: With the case managers. Can the case managers request the PAs or -- when they put it in the treatment plan it automatically generates --

MR. CALLEBS: For most services. Some of the higher cost services will still require Medicaid approval, but even still, you can get the kind of bread and butter services approved and PAs will automatically generate. And it will be a single PA, I'm told, that will be present on MWMA, that every --

MR. SHANNON: Which is an online management system, MWMA.

MR. CALLEBS: Yes. And every provider on a person's plan can go in and see -- see the

PA and the units and the approvals. There will no longer be PAs -- multiple PAs generated and sent out to all providers on the plan. Go to MWMA see a single PA for that person. We're told. So that's the plan.

MS. SCHUSTER: So what's --

PARTICIPANT: That's a good question --

MS. SCHUSTER: -- what's the overall timeline on this thing? I mean, is there going to be an end to this at some point?

MR. CALLEBS: I was told --

MS. SCHUSTER: It feels like it's been going on forever, so...

MR. CALLEBS: Oh, specifically for the PA.

MS. SCHUSTER: No, no. I meant for the -- for the whole redesign --

MR. SHANNON: The Navigant, the redesign.

MS. SCHUSTER: -- the Navigant redesign.

MR. SHANNON: I think that they're still wrapping up kind of overarching changes. And then they'll get into more detail in Phase 2.

MR. CALLEBS: In 2020. I think it will run all through 2020 is my --

MR. SHANNON: Yeah. I mean, it's...
MS. HASS: At a cost of what?
MS. SCHUSTER: Okay. So we have that to look forward to.
Anything else, Mary, on the ABI services?
MS. HASS: Yes, I have a couple things. On ABI services the good news is -- and a couple people here remember when I questioned the amount of slots that ABI had on their long-term care and that we were accessing all of those, well, somebody in the ABI branch -- and I see nobody from Medicaid is here, I wanted to bring this up -- they found 27 additional ABI long-term care slots, which we are very appreciative of. That means 27 people who have been on the long waiting list are receiving care now.
MS. SCHUSTER: Wow, good.
MS. HASS: So that was good news.
MS. SCHUSTER: Did they take them away from short term or did they just find --
MS. HASS: No, no, no. No, the acute. There's the two, the acute --

MS. SCHUSTER: Acute.
MS. HASS: -- and the long-term --
MS. SCHUSTER: Yeah.
MS. HASS: -- long-term care. No, that they have to be -- they were all long-term care. Those were where our longest waiting list was. At the present -- or, excuse me. When those came out, there was not a waiting list for acute, but I did hear the other day that there are a few people now waiting on the acute. I do not know the exact numbers since I'm not getting any comments back. So we'll continue on the search.

The thing that's most troubling to me, and this is brought up to me by both a provider and a family member, is, is that if you're under the acute care, that they are telling the family that they -- if they have been on there for a fairly long term, say, over two years, they will then have to decide to go on the long-term care. But right now, there's a waiting list. So you're receiving services under the acute, but then you would have to go under the

long-term care. Now, I've not gotten a response back on that, but that's very, very troubling, because you can have somebody who's been receiving services. And a lot of our folks the reason that they were under the acute is because there's a lot of behavioral issues. So we argued for that that they were able to stay under the acute because of their more heavily needs, or whatever, and that they were better served under the acute, which we all recognize acute initially was for rehab only, but that's not the way it has worked out in the process. So I'm trying to get answers on that.

And then the other thing that we're working on, both Diane and I are working on --

MS. SCHUSTER: Wait. Hold on a minute.

MS. HASS: Sure.

MS. SCHUSTER: Let me go back to this. Are they telling people if they are on acute for two years plus, or some length of time, that they have to get off --

MS. HASS: Yes.

MS. SCHUSTER: -- acute?
MS. HASS: Yes.
MS. SCHUSTER: So they have to empty out that slot, make that slot available to acute and -- but there is no slot over in long-term care.
MS. GUNNING: Right.
MS. SCHUSTER: So are they without services at that point?
MS. HASS: Yes.
MS. GUNNING: Right.
MS. HASS: Yes. So we haven't got that -- it has not happened in reality. But, again, it makes no sense. So, again, I'm working on that issue trying to -- so anyway. So right now it's -- and for the families who have been told that, especially if you have someone who has -- the one family that I'm working real hard with right now, the one that was told this, the person has severe needs. I mean, unfortunately, there are a lot of behavioral issues that are not going to be able to be served under the long-term care. It's just not.

MS. SCHUSTER: And there is no other --
MS. HASS: Well, we have two -- we have two waivers: Acute, long-term care.

And, you know, then we have other folks who are coming into the system that, you know, they're automatically all going to long-term care, which I can't understand. Yes, this person was fairly far post, but never received any type of rehab initially. So I'm arguing that case. I'm working on that one, too. But those are just a couple issues which I was hoping Medicaid would be here that I could ask that.
MS. SCHUSTER: They boycott us because we meet over here.
MS. HASS: I know, I understand. I understand. Bad people.

So anyway, and the other thing that Diane and I are working with again relates back to the waivers, is that we are seeing with the right supports a lot of our folks can be employable. We have a doctor at UK, Peter Meulenbroek -- and I probably butchered his last name, so I -- forgive me about that. But he has done a series of

studies and he's researching that on people -- not just brain injury, but -- his main focus is brain injury and a couple other spinal cord injuries, and there's one other and I can't remember what it is right now. But anyway, but he's showing great progress. He's working with two or three of our clients who are in the waiver.

So my thing is, how can we get his services. Now, he's got a -- he's got a grant right now paying for it going back, because under the waiver they say supportive employment will not pay for these services. I know. I know. So anyway, so I'm working on that. Those are the issues I'm working on right now.

MS. SCHUSTER: Okay. We're very glad we have you, Mary, and Diane as well.

MS. HASS: Well, and Diane has done a lot -- the way this is really evident, Diane is really the clinical person and then I take the studies and I reach it down into how it's going to affect real families and -- and real people. So, you know, it's a good partnership.

MS. SCHUSTER: So going into the 2020 session, are you-all fighting for more long-term care slots?

MS. HASS: Yes. All this is to be determined.

MS. SCHUSTER: Okay.

MS. HASS: We're literally right now working with the National Brain Injury Association, because we're looking at our agenda. We'll definitely do the helmets again on children. And then we're looking whether it should be a commission on brain injury; should there a department of rehab. How do we get these issues really addressed for people with brain injuries.

MS. SCHUSTER: Okay.

MS. HASS: But those -- those are to be determined because we're still in the process right now working on those.

MS. SCHUSTER: All right.

MS. HASS: And working on bill sponsors.

MS. SCHUSTER: Thank you. I think we have lots of recommendations. I'm not looking for any more because we have about ten.

MS. HASS: No.

MS. SCHUSTER: Other issues and updates from anyone?
MR. SHANNON: I have an update on the nonemergency transportation.
MS. SCHUSTER: All right, Steve.
MR. SHANNON: I looked at the reg. And the reg says, the person needs to use a stretcher. Yeah, nonemergency, 907 KAR 1:060. This is ambulance ride with nonemergency ambulance services, a nonemergency ambulance service who -- within -- to provide within a medical service area shall be covered if the recipient's medical condition warrants transport by stretcher.
MS. SCHUSTER: But nobody has said that to you?
MR. KELLY: No. Ambulatory. They said if they're ambulatory.
MR. SHANNON: They don't need a stretcher.
MS. GUNNING: We'll put everybody on the stretcher.
MR. SHANNON: Yeah. Warrants transport by --
PARTICIPANT: Can't walk -- put them on a

stretcher.

MR. SHANNON: But, again, if you're --

PARTICIPANT: Put them on a stretcher.

MR. SHANNON: Wait, wait, hold on. If you don't want to transport the person, you're going to say, it doesn't warrant a stretcher.

PARTICIPANT: Right.

MR. SHANNON: So it's a Medicaid problem; it's the reg problem.

MS. SCHUSTER: What's the reg number?

MR. SHANNON: 907 KAR 1:060.

MS. SCHUSTER: Okay. Good for you.

PARTICIPANT: Has it always been that way, Steve, or is that a recent change?

MR. SHANNON: I didn't check. I think it's always been that way.

MS. SCHUSTER: I think it probably has been.

MR. SHANNON: Medicaid has no interest on putting the reg on hold, the emergency piece.

They aren't being put on hold to Stephanie Bates' knowledge.

MS. SCHUSTER: Are you talking about the

BHSO regs?

MR. SHANNON: BHSO regs.

MS. SCHUSTER: Okay.

MR. SHANNON: Comments submitted by the BH TAC during the comment period.

MS. SCHUSTER: They were submitted by the Kentucky Mental Health Coalition.

MR. SHANNON: Yeah, so there's comments.

MS. SCHUSTER: Yeah.

MR. SHANNON: But I think that's her insight that -- and I never thought the BH TAC could submit comments. I mean, we could, but other people didn't.

MR. BALDWIN: That's interesting.

MR. SHANNON: Now we know.

PARTICIPANT: Can we collect all of ours and we submit them as a group?

MS. SCHUSTER: Yeah, yeah, we could.

MR. SHANNON: Yeah, and missed the date.

MR. BALDWIN: The TAC. Yeah, they got plenty of comments.

MR. SHANNON: They got comments. But going forward, TACs ought to be submitting comments, right? That's the message from that e-mail.

MS. MUDD: I thought we weren't allowed to talk to anybody but the MAC.
MR. SHANNON: It's comments.
MS. SCHUSTER: Is that consistent with our big advisory to the MAC?
MR. SHANNON: She asked if they were submitted. That must mean they're allowed.
MR. BALDWIN: Maybe Stephanie is trying to give us a little do this and try this.
MR. SHANNON: I got to be in Lexington at 4:00.
MS. SCHUSTER: The golden rod sheet, one side are managed care forums that the MCOs are having for all providers. So I'll get this to you electronically. You can send it out. The other side are a series of advocacy training that Kentucky Voices for Health and other organizations working with them. They're really neat. What we do is do the first hour and a half. It's about Medicaid and SNAP and TANF, and the census, and housing and mental health and substance use. In other words, issues briefing. And then the second half is my super-duper Dr. Schuster, everybody should be an

advocate. And you just really don't want to miss that. So these are free. Sign up. We're coming to Morehead. Did you see that? Okay. So spread those around.

We are not meeting on election day. We changed that meeting to the Monday, November the 4th. We'll be here in the annex at 1:00. And then the MAC meeting is September 26. And we are adjourned if nobody else has anything else to add.

MR. KELLY: So moved.

MS. SCHUSTER: So moved. All right. Take care. Thank you all very much.

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THEREUPON, the proceedings concluded at 3:02 p.m.

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STATE OF KENTUCKY)

COUNTY OF FAYETTE)

I, JOLINDA S. TODD, Registered Professional Reporter and Notary Public in and for the State of Kentucky at Large, hereby certify that the foregoing record represents the original record of the proceedings of the Behavioral Health Technical Advisory Committee; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

My commission expires: August 24, 2023.

IN TESTIMONY WHEREOF, I have hereunto set my hand and seal of office on this the 27th day of September 2019.

JOLINDA S. TODD, RPR, CCR(KY)
NOTARY PUBLIC, STATE AT LARGE
ID# 449787